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THE SALVATION PROJECT

THE SECULARIZATION OF CHRISTIAN NARRATIVES

IN AMERICAN CANCER CARE

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A c k n o w l e d g e m e n t s

After four years of college, I have realized that my education is best defined not by the classes I took or the papers I wrote or even the books I read, but by the people who have entered into my life. There are many for me to thank, and I'm going to be honest – I'm not really thanking them for the help they provided on this particular project, though for their tirelessness I am eternally grateful. Rather, I thank them for the ways in which their mentorship has turned me into the sort of student who can write a thesis in the first place. I only ask that for once they please lay aside their humility and grant me the privilege of singing their praises.

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PROLOGUE : NARRATING DISEASE

I will rejoice over Jerusalem
and take delight in my people;
the sound of weeping and of crying
will be heard in it no more.
Never again will there be in it
an infant who lives but a few days,
or an old man who does not live out his years;
the one who dies at a hundred
will be thought a mere child;
the one who fails to reach a hundred
will be considered accursed.

Isaiah 65: 19-20

People have been dying ever since there have been people. Yet even if we can count on death as a constant, humanity's response to death remakes itself time and time again. The way each person approaches the end of life emerges from an ever-shifting milieu of cultural traditions, religious beliefs, and scientific advancements, all of which frame particular ways of understanding the value of life and the meaning of medicine. In our contemporary moment, leaps and bounds in biomedical research have made possible a new form of death: the technical one. Cutting-edge treatments and state-of-the-art technologies can give us years of life, but they also allow us to postpone death and

prolong dying in ways no previous culture has ever known. Death at home or the hospital, palliation or resuscitation, last rites or a last fight – these are choices we must make when we approach the end, decisions foreign to generations who have come before.

How do we decide? What determines how we choose to die? I argue that our decisions are informed by cultural narratives, stories that circulate in our societal subconscious. Narratives manifest themselves in the way we speak and write and think about the world, and if there is any subject for which humans have always constructed narratives, it is the subject of death. This paper will explore one of these narratives. The advances of biomedicine suggest that science can stave off death. They make possible a crusade for unlimited life and secular salvation, an endeavor that echoes Christianity's promise of eternal life.

America is not an explicitly Christian nation, but Christianity still digs deep roots into the nation's cultural consciousness. In America, one does not need to profess the faith in order to be sensitive to its narratives, and because Christianity has a lot to say about death, its theology can inform the ways Christians and non-Christians think about the end of life. Some scholars suggest that the legacy of Puritanism and the presence of Protestantism in America contribute to the formation of sacra-social space, decidedly secular spheres that still whisper of the divine¹. Medicine, I argue, is one such sphere.

Americans can construct a narrative about death that merges Christian archetypes with medicine's quest to extend life. The doctor becomes the savior, the disease becomes the demon, and illness itself plays the part of sin. As we will see, these archetypes play

¹ Sacvan Bercovitch and Tracy Fessenden both explore the presence of the sacred in supposedly secular spaces in their respective books *The Puritan Origins of the American Self* (1975), and *Culture and Redemption* (2007).

² Literary critics suggest that the purple coat refers to Abse's occupation as a poet as

out in medical TV dramas and medical school ceremonies, in newspaper articles and public health policy, in images of disease and rhetoric about cures. Contemporary biomedicine has therefore reconfigured the Christian narrative of redemption into a secularized crusade against the end of life. Americans place their faith in Christ-like physicians who strive to purge them of the sins of illness and ward off the devils of disease. Thus, salvation from sin in the Christian narrative becomes salvation from death in the medical one. By clinging to the promises of scientific progress, many seek to create a modern-day Jerusalem like the one the prophet Isaiah imagines – one in which no one weeps, no one cries, and most importantly, no one dies.

Yet this pseudo-religion rings hollow at the end of life, when no earthly power – not even that of the super-human physician – can bring the patient from the brink of death. However, after conceptualizing the medical experience as a righteous battle for life, doctors and patients grapple with the reality of death. Contemporary medicine struggles under a blanket imperative: to treat, to heal, to cure – to rescue the patient from the edge of death with all the power of biomedicine invested in the physician. Thus, dominant Christian narratives recast in the medical space may begin to explain aggressive treatment at the end of life, lack of appropriate conversations about palliative care and hospice, and an overall cultural inability to accept death as a natural part of life.

This essay explores the extent of these secularized Christian narratives in American culture by performing a close reading of the rhetoric and imagery that surrounds doctors and disease. In particular, I turn my attention to cancer. Because of the fear it summons as well as the challenges it presents to patients at the end of life, cancer becomes a fitting enemy for the doctor and the patient who rally against the possibility of death.

THE DOCTOR : A SECULAR SAVIOR

How lost was my condition

Till Jesus made me whole!

There is but one Physician

Can cure a sin-sick soul.

18th century hymn, John Newton

A symbolic system saturates the practice of medicine. A hospital bed, a stethoscope, a white coat – these articles perform not only their utilitarian but also their ritualistic functions, swathing each medical encounter in layers of shared meaning. If we want to know what medicine *means*, we must dissect the semiotics of its players – the objects and the people and the spaces that turn the idea of medicine into the physical reality of medicine. We begin first, then, with the physician.

The Doctor and the Divine in History

The doctor has long held a place in the realm of the divine, at some times more explicitly than others. Ancient Western myth credits Apollo with the art of healing, and

the original Hippocratic oath addresses its vows to him, among other Greek gods (Kronegger 62). According to the mythology, the divine Apollo passed on healing practices to his mortal son Aesculapius, and medicine became the dominion of humans as a gift from the gods. Hippocrates himself, in fact, claimed to be the descendant of Aesculapius.

The relationship between medicine and divinity continued in the Christian tradition. In fact, historian Gary Ferngreen argues that the concept of healthcare as a communal obligation emerged out of a Christian response to the Roman Empire's neglect of the infected during epidemics. The state banished the sick to the streets in the 3rd century. Hoping to mirror Christ's compassion for the ill, Christians organized ambulance and healthcare systems for those abandoned by Rome (Astrow 101).

The doctor's God-like ability to treat the ill and Christ-like compassion for the sick encouraged consistent connections throughout history between medicine and spirituality. The subject of life and death was the domain of not only the physician, but also the priest, who oftentimes were one and the same. In the middle ages, monks provided healthcare, and the monastery later became the model for the hospital (Crislip). As late as the 18th century, inhabitants of some pockets of rural England looked to their priests for medical advice (Heller 362). Thus, historical conceptions of the doctor emerged from religious contexts. As a gatekeeper at the doors of death, the human healer served as a mediator between the earthly and the divine. Stewards of life, physicians appeared to possess rare spiritual authority.

Medicine retained its spiritual connotations over time; religious orders have founded hospitals around the world, and physicians wore black before the 20th century to

mimic the garb of clerics (Wardlaw 70). Even today, doctors occupy hallowed ground in the social hierarchy. It remains one of the last non-clerical professions still considered a vocation, a term originally used to reflect God's call to ministry (67). In fact, in a 1995 official address to the American Medical Association, Cardinal Joseph Bernardin, Archbishop of Chicago, stated that clergy and doctors shared a distinctive societal meaning; they are "both engaged in something more than a profession – a vocation" (Siberski 22). A vocation implies a special role, a sacred function; according to the cardinal, the priest and the physician both address "the universal human need for healing and wholeness" (Bernardin). A doctor echoes Bernardin's sentiments in the *British Medical Journal*, explaining that the weighty responsibility and noble mission of medicine renders it a vocation. Utilizing the language of faith, he writes, "vocation is something that professionalism will never be: something to believe in" (Spence 344). It is no wonder, then, that Bernardin titled his address, "Renewing the Covenant." So profound is the doctor's commitment to her patients that it resembles a covenant, a sacred promise to God's people.

Perhaps for the same reasons we call medicine a vocation, physicians occupy a special place in the social hierarchy. The MD draws respect; in a 2006 poll published in *Forbes*, doctors ranked as the second most-admired professionals, trailing behind firefighters (Van Riper). The white coat confers not only status, but also a reputation for moral integrity upon the doctor. Veneration for the physician remains fairly stable even as political firestorms cause the foundation of medicine to shift around them. A 2011 Gallup poll revealed that public trust in the integrity of doctors has actually risen steadily over the past five years, despite increasing cynicism towards the American healthcare

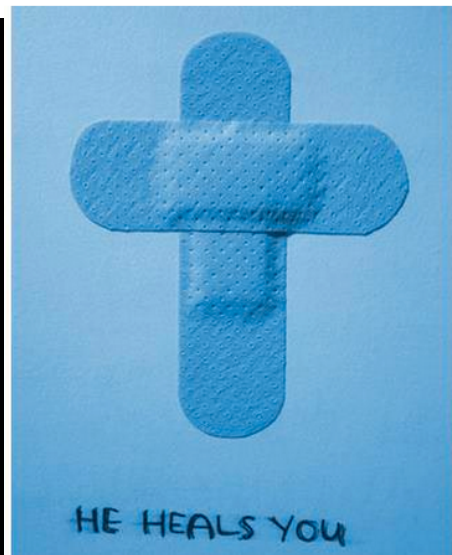
system (Sanger-Katz). Another poll one year later reinforced physician's esteem; the public ranks the physicians third in a long list of professions with the highest ethical standards, just after nurses and pharmacists (Gallup). Thus, our society glorifies its doctors not simply for their supposed intelligence or importance, but also for their moral goodness. Their role at the intersection of life and death, combined with their perceived integrity, turns doctors into pseudo-spiritual figures who possess both the authority and the mercy of a deity. Charged with sacred responsibility and viewed as morally distinguished, physicians often enjoy an almost religious reverence.

In America, a country nested in the narratives of Christianity, the divine qualities of the physician can sometimes assume a distinctly messianic feel. The archetype of a simultaneously human-yet-divine mediator between heaven and earth applies not only to the physician, but also to Jesus Christ. At once both God and man, he serves as the bridge between the Father and his children and directs sickly sinners to the gates of Heaven. Theological discourse sometimes refers to Christ as the ultimate physician, pointing to both his miraculous acts of healing in the Gospels, as well as his power to heal the broken of their sins and thus gift them with eternal life. Indeed, Christ calls himself a physician in Luke 4:23, and theologians have echoed his language ever since – St. Augustine writes, “Thou art the Physician, I the sick” (Kronegger 63).

The same allegory manifests itself today in a variety of spaces, including the visual. The nation's top microblogging platform, *tumblr.com*, hosts a number of images posted by users, many of whom also report updates on their own illnesses, that merge the identity of the doctor and the savior (see figure 1). In two such images, Band-Aids form a cross. One picture states “Jesus heals;” the other, simply “He heals you.” The words

could refer to multiple types of healing; the symbol of the cross suggests salvation from sin, but the physicality of the bandages implies salvation from illness. The third image presents a similar ambiguity. Sandwiched between block letters that read *JESUS HEALS* is the familiar symbol of the American Red Cross. Yet the picture's Biblical reference reclaims the secular icon and reconfigures it as a Christological cross, thus merging the semiotics of the medical and the divine.

Figure 1: Jesus as the ultimate physician - images taken from microblogging platform *tumblr.com*



These images invite Jesus into the hospital, not only blurring the line between spiritual and physical healing, but also suggesting that they may sometimes be one and the same. When Christ serves as the physician, the medical space becomes sacred. By intertwining the images of the doctor and the savior, the allegorical tradition infuses the physician's identity with theological import. Consequently, the cultural perception of the doctor in America often adopts a Christological form. Just as 3rd-century Roman Christians attempted to mirror Christ in their care for the sick, the doctor, in the eyes of many, acts in imitation of the messiah and practices the holy art of healing.

For some, the Christ-like function of the physician emerges from personal faith. Physician Dan Foster, member of the President's Council on Bioethics, explains that he "see[s] in the patient's fight, [his] fight" because he follows Christ, who "identifies with the woundedness of the world" (qtd. in Goldberg 104). Yet one does not need to profess the Christian faith to imagine physicians in a Christ-like role, for the word *savior* has entered secular rhetoric. In popular media, the language of salvation often imbues references to physicians. Historians typically dub Ignaz Semmelweis, the Hungarian physician who discovered the importance of hand washing in an obstetrics ward, the "savior of mothers" (Independent). Stateside, Bob Woodruff titled his ABC News piece on American doctors in Iraq, "Frontline Reunion with Saviors." *The New York Times* titled a 2010 article on a doctor who fought to take dangerous drugs off the market, "The Public's Quiet Savior From Harmful Medicines" (Gardiner). In 2012, CBS News produced a story on rural medicine called "Mississippi doctor a saint with a stethoscope." Similarly, another *New York Times* piece on doting doctors began, "She was their friend, their advocate, and their savior, grieving at every mishap from divorce to pneumonia, and

rushing to heal their pain” (Zuger). By referring to her as a savior, the article suggests that the featured physician plays Christ in the clinic, taking on the suffering of others as her own and coming to the aid of patients in pain. Overall, the plethora of instances in which “savior” refers to a doctor suggests that the ancient Christ-as-physician allegory continues to inform our contemporary understanding of the doctor.

Messianic imagery transposed upon the modern physician even extends to the medical training process. Popular entertainment reveals a public fascination with the educational and emotional development of doctors; personal memoirs that chronicle the doctor’s experience abound, many of them honing in on the years of residency. From *St. Elsewhere* to *ER*, *Scrubs* to *Grey’s Anatomy*, all of which prominently feature young doctors, medical television shows have become incredibly successful, occupying primetime spots on nearly every major network (Hirt; Davin). These shows depict the development of doctors as an epic journey laden with trials. In fact, the maturation of these fictionalized doctors-in-training often follows the narrative arc of Joseph Campbell’s Christological monomyth. In his seminal work *Hero With a Thousand Faces*, Campbell outlines the archetypal journey of the Christ figure, among other heroes in various world mythologies. According to monomyth theory, Jesus progresses through various stages as he prepares to begin his ministry. Campbell’s theoretical apparatus also applies to the plot progression of various hospital dramas. The Christological monomyth manifests itself in a medical space; interns and residents pass through the same stages on their way to assuming the sacred position of doctor.

For example, in pursuit of the noble status of *physician*, doctors-in-training on the small screen receive what Campbell calls a “call to adventure,” often in the form of an

initiation ceremony. The first episode of *Grey's Anatomy*, for instance, begins with a doctor addressing a cluster of new residents. He scans the solemn faces and says, "A month ago you were in med school being taught by doctors. Today, you are the doctors." The scene takes place before the new doctors enter the hospital proper and therefore marks a fundamental transition in the growth of the characters. The moment of initiation thus functions as a baptism similar to that of Christ's, which marked the beginning of his public ministry.

After the "call to adventure," the aspiring physician must face what Campbell calls the "road of trials." The burdens of medical school and residency operate as a time of testing for young doctors. Their experience recalls that of Jesus, who endured suffering and temptation by Satan in the wilderness immediately after his baptism. Like Christ in the desert, would-be doctors enter a space laden with temptation. Moral corruption threatens the trainee at every turn; they could become the stoic doctor, the patronizing doctor, the doctor who loses their starry-eyed idealism to pursue the quickest route to a fat paycheck and a fatter ego. In fact, studies show that emotional overload and overwork cause many doctors to exhibit a loss of empathy and a rise in cynicism over the course of their medical training (Bazari, Griffith 416).

Yet doctors who move through their education without losing their empathy enter the moral high ground – they become the professionals with integrity to whom the *Gallup* polls refer. In fact, some researchers suggest that this painful rite of passage is crucial for the moral formation of physicians. As Dr. Michael Green wrote in the *Annals of Internal Medicine*, "Self-sacrifice and suffering provide a meaningful way to formalize the change in status that occurs as novices become experts" (513).

Trial thus prepares doctors for their sacred role in society, just as Christ's time in the wilderness readies him for his ministry in the world. Campbell explains that in the Biblical account of testing in the desert, "Jesus passes each of these three temptations, the narrative moves more firmly to Jesus' divinity." Time in the wilderness, whether it is a Judean desert or a hospital ward, moves the individual into their sacred function. A period of suffering refines the newly christened physician, and if she emerges unscathed, she already emerges a hero.

Medical training, then, exists as a liminal space for the doctor – after passing through the dark underworld of sleep deprivation and the hostility of senior physicians, they arise wearing the mantle of the martyr. The ethic of selflessness saturates their profession; as a 2009 Kasier Family Foundation poll discovered, 78 percent of respondents felt that doctors put patients' interest above their own (Sanger-Katz). Thus, a period of Christological trial imbues doctors with an aura of Christological self-sacrifice.

This faith in the moral integrity of the physician allows a patient to trust her doctor with the fragility of the body. Only then can the doctor perform the same role that Jesus did: that of healer. The ability of the physician to relieve suffering, made possible by her secret knowledge and special skills, grants her with the near-sacrosanct power over life itself. What the doctor does in the clinic thus looks a little like what Jesus does in the Bible – so much so that philosopher Michel Foucault writes that physicians are "invested, at the level of man's bodily health, with powers similar to those exercised by the clergy over men's souls" (Foucault 31).

Foucault notices the similarities between authority over the fate of the body and authority over the fate of the soul. Both the sick in spirit and sick in body turn to a figure

with special powers. Thus, the clinical interaction carries connotations that link the physician and the patient to the savior and the supplicant. Scholar D.W. Blumhagen points out that the very imagery of surgery looks like a religious rite. Christ raises Lazarus four days after his death; similarly, the surgeon “send[s] a person into a deathlike state, open[s] the previously inviolable body cavities, correct[s] whatever was ‘wrong,’ and resurrect[s] the patient, healed” (Blumhagen 112). Doctors thus enter the inner sanctum of the body itself. They are the chosen ones who ward off death and heal the broken with gloved hands.

Yet the physician need not enter the body to exert God-like authority over illness. Hands lie at the heart of healing, and for Christ figures, a gentle touch can mean more than any scrape of the scalpel. The leper, the blind man, the bloodstained woman, the paralytic – Jesus conquers their ailments with just one touch (Mark 1:40; 8:22; Matthew 8:3; 9:21; Luke 12:12). Faith in Christ’s touch, in fact, can signify faith in Christ himself; in Matthew 9:18-20, a ruler kneels before Jesus and says, “My daughter has just died, but come and lay your hand on her, and she will live.” The supplicant believes so strongly in Jesus’ power that he knows a single touch will heal his child.

Contemporary scholarship suggests that many patients often place the same faith in the touch of the doctor as the ruler did in the touch of Christ. The novelist and physician Abraham Verghese explains that patients often complain when their doctors never touch them; despite cutting-edge imaging and computerized diagnostic technology, the sick still expect a touch and still perceive its inherent power. In touching the patient, Verghese becomes aware that both he and the patient have “entered some sacred space by virtue of this ritual and ha[ve] been transformed” (1178). This is not simply human touch

– this touch creates a bond that moves the patient towards physical and psychological healing. The physical examination thus becomes a holy sacrament; Verghese writes, “A careful exam invokes the mythic rites of priest and confessor, of saint and disciple, of healer and sufferer” (1179). The ritual of touch roots the doctor and the patient in a hallowed act, calling to mind the healing hands of Christ. It conveys the same message of selfless devotion that Jesus delivers to God’s children: in Verghese’s words, “I will always, always be there...I will never abandon you. I will be with you through the end” (1182).

The medical technophile may argue that cutting-edge diagnostic imaging has by and large rendered the physical exam unnecessary, but the way patients and doctors such as Verghese revere the act demonstrates that medicine relies not simply on science or technology, but also on ritual. The physical examination serves as a sacrosanct rite, a practice crucial to the trust-based relationship between those who are sick and those who heal them. The patient lies naked before the doctor as scripture calls Christians to stand naked before God, the motives of the heart exposed (1 Corinthians 4:5). The physical examination thus implicates us in a ritual of submission before compassionate authority that names the patient as the worshipper and the physician as the Christ-like healer.

The White Coat: A History

The physical examination is only one of several symbolic acts that construct the realm of the sacra-medical. The donning of the white coat also functions as a signifying gesture, one of so much import that in the past two decades medical schools across the

country have instituted a “white coat ceremony” for its incoming students. Yet although the ceremony itself may be new, the symbolic significance of the white coat dates back to the late 19th century.

For centuries, doctors donned black. Limitations on medical knowledge and misguided attempts to cure meant that the ill sought medical advice as a last resort – leeching and bleeding does not a healthy person make. The hospital served as a house of death and the doctor its merchant; indeed, in the 19th century, the Austrians used to say that those entering the Vienna General Hospital were guaranteed the best post mortem in Europe (Forrester). Physicians, then, wore black to match the color of clergy who arrived at deathbeds to guide patients passing from this world (Jones 478). Medicine was a somber affair, and a visit with the doctor often acted as a final stop before death. Physicians may have looked like clergy, but they certainly weren’t saviors.

The advent of modern germ theory, however, transformed the function of the physician in the late 19th century. Once science could provide an accurate mechanism for the spread and contraction of disease, medicine transitioned from what we now view as home remedies, herbal hopes, and show-trick quackery to an admired profession bolstered by bioscience. Antisepsis meant anti-death, and so the location for healing the sick shifted from the home to the hospital. No longer was the hospital bed the final stop for society’s outcast; instead, modern surgery and diagnostic technology turned the hospital into the sick’s only hope for healing. Soon after advances in medical technology, the Carnegie Foundation for the Advancement of Teaching published a book-length study called the Flexner Report, which called for stricter adherence to mainstream science in medical education. Its publication resulted in the closure of several medical schools that

lacked an appropriate emphasis on laboratory science (Ludmerer). It was in the midst of this shift towards modern biomedicine that the image of the white-clad doctor emerged; a 1889 photograph provides early evidence, depicting surgeons in white coats at Massachusetts General Hospital (Hochberg).

The arrival of white uniforms, then, heralded a new era of medicine – one built upon the fundamental assumption that the hospital functioned as an institution of healing rather than as a house of death. Physicians shed their macabre trappings for holier, more hope-fused garb, and a former director of Michael Reese Hospital in Chicago tells us that “all people connected with the healing process (including patients and visitors) were to be dressed in white, whereas the *nonmedical* employees were to be given colored uniforms” [emphasis in original] (Kavan). The new coats, then, symbolized healing. They signaled to the sick that they were going to be saved. Thus, the image of the doctor changed from black to white, from sickness to health, from death to life.

The switch in uniform may have occurred during a period of scientific advancement, but it reflected much more than expanding knowledge. Hospitals wanted to convey a message of scientific faultlessness, and so had adopted the uniform of scientists. Yet scientific lab coats of the time were actually beige; it was not until they made the transition from laboratory to hospital that they became white (Jones 478). Thus, the white coat did not signify *science*; it signified *science in the practice of healing*.

White is no neutral color; it connotes virtue and goodness. The Latin word for white, *candidus*, later gave rise to *candor* (Hochberg). Untainted and chaste, white conveys holiness – cultural imagination often envisions a heaven filled with white clouds and white-robed angels, and the alb, one of the liturgical vestments of various Christian

traditions, is made of white linen. Jesus and Moses on occasion appear in white, and the ancient Israelites wore white on festival days (Exodus 34:29; Luke 9:26; Ecclesiastes 9:8). In Revelation 7, those beyond the touch of death who have found eternal life wear white robes. Paintings featuring Christ after his resurrection almost always show him wearing white, thus reinforcing white as a symbol of triumph over death (Wardlaw 70). Even now Western cultures use white as a symbol of life at baptisms, weddings, or other celebrations, whereas some cultures without Judeo-Christian roots – China, Vietnam, and India, for example – understand white as a symbol of mourning.

Figure 2: *Alexis Carrel's black operating room earned him a gruesome reputation in the 1920s*



Long after doctors donned white, Western culture still associated its converse, black, with death. Medical students studying cadavers wore black well into the 1920s to show their respect for the dead, and Nobel prize-winning surgeon Alexis Carrel gained a

reputation as a morbid madman-genius when in the 1920s journalists reported that he had painted his New York operating room black and insisted that his staff wear only black clothing and masks (Alexis). His color preferences stirred enormous controversy, despite black physician's robes having been the norm half a century before (see figure 2).

In contrast, the white coat means that doctors do not deal in death. As one scholar wrote, the coat serves as a sacred vestment, and with the advent of modern medicine, the "physician's ability to ward off mortality (and, by extension, the unknown) became bound up in the allegory of the white coat" (Goldberg 103). Clothing communicates, and for the hopeful patient or promising doctor, whiteness speaks of life. Thus, unlike its beige forerunner, the white coat conveys not only the authority of the scientist, but also the life-giving power of the divine. Yet the white coat does not always remain unsullied; some historians argue that doctors began to wear white because it made bloodstains, among other marks, more apparent (Carter 3). Indeed, in his mid-20th-century poem *Song for Pythagoras*, physician-poet Dannie Abse suggests that the coat stained red remains a central component of the doctor's image. He writes,

*White coat and purple coat*²

A sleeve from both he sews

The white is always stained with blood,

That purple by the rose,

² Literary critics suggest that the purple coat refers to Abse's occupation as a poet as opposed to his work as a doctor (Coulehan). Those who are interested can read more of Abse's poetry in *White Coat, Purple Coat: Collected Poems, 1948-1988* (New York: Persea, 1991)

And phantom rose and blood most real

Compose a hybrid style

White coat and purple coat

Few men can reconcile

The white coat, as Abse sees it, is “always” stained with blood; in fact, so deeply entrenched is the image of blood that it composes the “style” of the physician, incorporated into her identity. The blood completes the coat; the coat completes the doctor. Doctors no longer sport their stains, but as late as the beginning of the 20th century, blood still served as a badge of honor, the mark of a true doctor (Herbst 28). The connection between the white coat and the red blood, moreover, contributes to the association of the physician with cultural representations of Christ. Red on white turns the physician into the bloodstained lamb, the virtuous savior ready for any personal sacrifice and devoted to securing life for the suffering. Abse’s poem thus underscores the Christ-like selflessness of the doctor, a connection reinforced every time it appears in speeches given at white coat ceremonies (Irving).

The white coat drapes the doctor in layers of meaning – the coat itself communicates the power of science, but the color white suggests blamelessness and virtue. A white coat thus merges technical prowess with Christological goodness, thus conferring upon the physician the sense of virtuous authority that so many patients desire. Doctors in advertising materials for hospitals almost always wear white coats, as they function as a crucial component of the public image of “The Doctor.” A 2005 survey published in the *American Journal of Medicine* found that 75 percent of patients prefer to

see their doctors in white, finding it easier to trust the professionally garbed physician. In fact, patients whose doctors wore white coats actually demonstrate greater compliance with doctor-prescribed treatment regimens (Karnath). Thus, the coat itself has meaning, altering the behavior of those who see it.

It is not only patients, but also doctors who cleave to the meaning of the white coat in times of crisis. A doctor at the Louisiana State Medical Society noted that in the immediate aftermath of Hurricane Katrina, every single doctor chose to wear their white coats, even faculty members who had previously forgone them in favor of more casual dress (Summer). In the chaos of natural disaster, the coats communicated a sense of order and goodness craved by doctors and patients alike.

The White Coat in Visual Media

We can also trace the transformation of the doctor from merchant of death to savior of life in the artistic production of the physician figure. The following images, *The Gross Clinic* (1875) and *The Agnew Clinic* (1889), are two of the most famous depictions of doctors in the art world; in 2002, *The New York Times* called *The Gross Clinic* “hands down...the finest 19th century American painting” (Kimmelman). The images continue to crop up in modern references to physicians; JAMA³ made *The Gross Clinic* its cover in both 1964 and 1983, and *The Agnew Clinic* its cover in 1986 (Albert). In fact, so widely circulated are the two paintings that the pamphlet for the 2012 UNC White Coat Ceremony displays both on its front cover.

³ Journal for the American Medical Association, one of the most prestigious publications of the medical profession

Figure 3: *The pamphlet for the 2012 UNC White Coat Ceremony features The Gross Clinic and The Agnew Clinic on its front cover.*

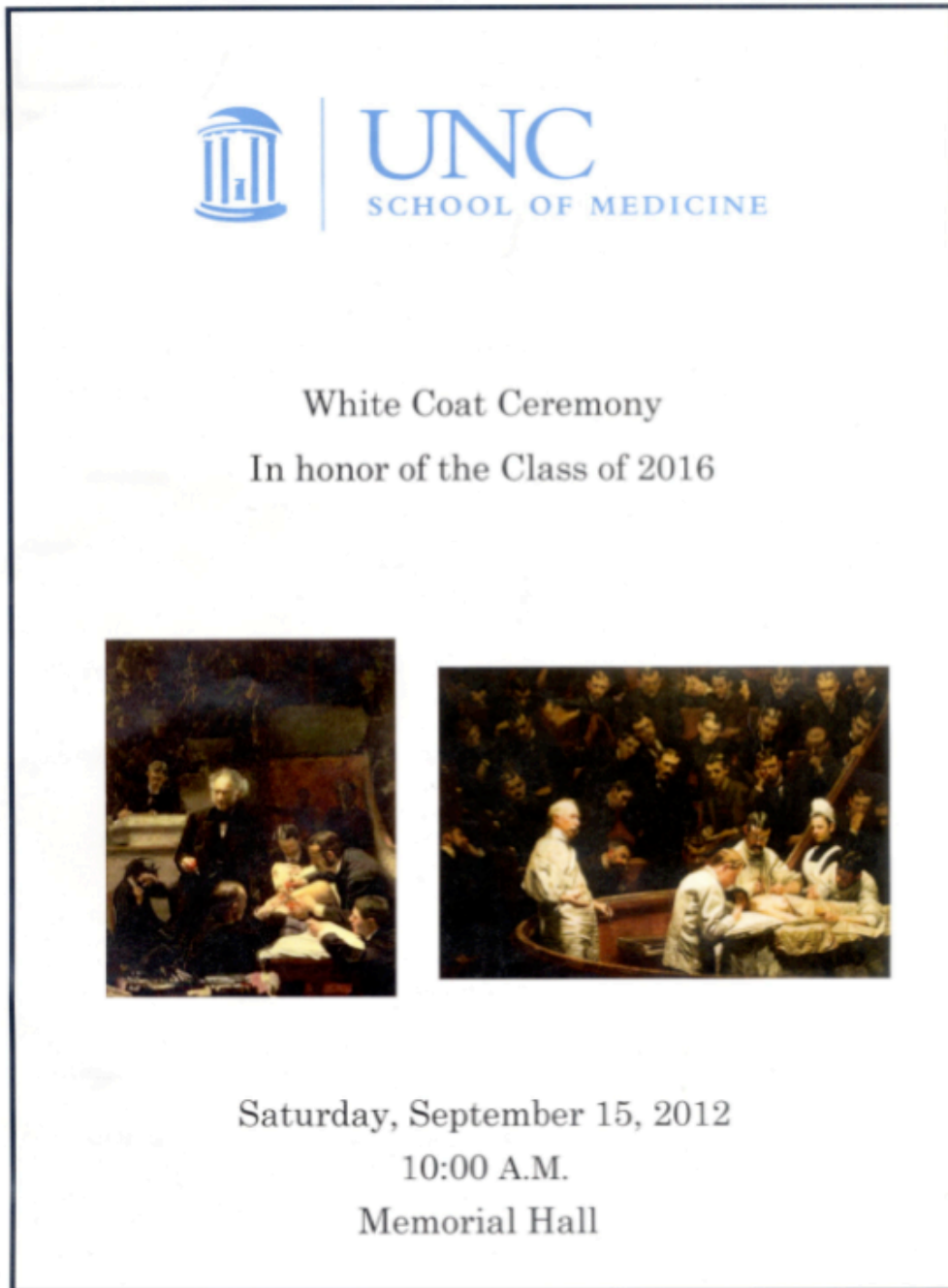


Figure 4: *The Gross Clinic*, Thomas Eakins (1875)



Figure 5: *The Agnew Clinic*, Thomas Eakins (1889)



The first image, painted in 1875, depicts the doctor before the introduction of the white coat. The second, painted only fourteen years later, shows the doctor and his assistants in white (Figure 4 and 5). A juxtaposition of the two images reveals the stark contrast between not only the clothing of the two doctors, but also the overall tone of the paintings themselves. In the first, light comes down in splotches and leaves much of the operation in shadows. The surgeon looks grim, his face turned away from the patient, who appears to us only in a tangled mass of bloody limbs. In the second painting, light shines upon everyone in the arena, particularly so on the head surgeon. He stands back,

hands open with palms turned towards the sky, and casts his gaze upward. Bathed in white light, he stands confident and contemplative as his unmarred patient lies snug under the covers and care of the hospital staff.

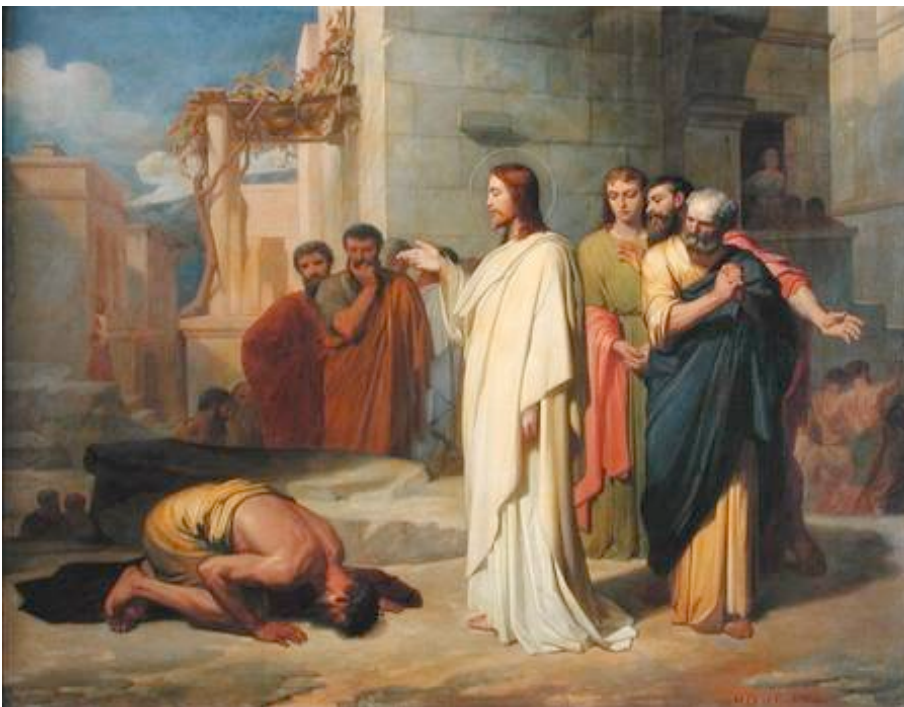
The progression of the two paintings registers a transition in medicine. The same artist, Thomas Eakins, painted both pieces. He produced the first in 1875, just as advances in medicine had begun to improve the doctor's ability to stave off death. The second image appeared when transformation of healthcare was well underway and doctors had begun to don white coats. The latter painting thus follows a revolution in not only what medicine was able to do, but also what it was expected to do; scientific progress gave patients faith in their physician's power to save them.

The first picture depicts a doctor all-too familiar with death; the second shows us a doctor confident in his ability to preserve life. The latter surgeon, with his calm authority over life and death, thus resembles a holy figure. In fact, in posture and in color the painting bears a strikingly similar resemblance to images of Christ performing miracles of healing (Figure 6). Painted between 1862 and 1883, the same time period as the Eakins works, the following paintings depict a Jesus who, like the surgeon, stands amidst white light above the patient, hands outstretched. Onlookers observe with awe, and we sense the presence of the divine. Thus, as medical science progressed and doctors donned white coats, Thomas Eakins' depiction of the surgeon began to adopt the artistic conventions concerning the depiction of Christ.

Figure 6: *Jesus as the healer*



a. Jesus Healing Jairus' Daughter (Mark 5:21-43), Philip Lodewijk Jacob Frederik Sadée,, 1862



b. Jesus Healing the Leper, Jean-Marie Melchior Doze, 1864



c. Healing by the Pool of Bethesda, Carl Bloch, 1883

Images of medical healing in contemporary culture continue to draw upon artistic images of Christ. In various TV stills taken from contemporary medical dramas, depictions of doctors remind the view of depictions of Jesus in the earlier paintings (see figure 7). Light floods from above and focuses attention on the bright-white physician, whose height and posture communicates authority and confidence. These depictions, then, call upon conventions of the holy. Recent television shows such as *Grey's Anatomy* or *E.R.*, however unknowingly, echo Biblically-inspired images of healing and thus craft sacred spaces in secular settings.

Figure 7: *TV stills*



a. Grey's Anatomy



b. E.R.



c. E.R.

The White Coat Ceremony

The figures depicted in the previous paintings share one characteristic: whether the 1889 Eakins surgeon, Jesus Christ, or Meredith Grey of primetime fame, all wear white. There is something about the white coat that reminds us of the art of healing. So important is the symbolic function of the coat that medical schools began to adopt the white coat ceremony less than two decades ago; reverence for the white coat is not a remnant of an older way of thinking, but rather a tradition recently renewed and reaffirmed as central to the modern practice of medicine and placed at the very beginning of a doctor's training.

Physician Arnold P. Gold instituted the first White Coat ceremony in 1993 at the Columbia University College of Physicians and Surgeons in New York (Karnath). Since then, schools across the country and around the world have adopted the tradition (Huber

364). The ritual baptizes new students into a doctrine of care. It serves as the first step of the medical moralization process, one that immediately grants the student a Christological identity. Ceremony officers sometimes call the transfer of the white coat a “gift of faith” and oftentimes use the language of robing (Veatch; Summer). The pamphlet for the 2012 ceremony at UNC School of Medicine explains that the ritual “captur[es] students’ attention at a strategic and impressionable moment” and “cloak[s] [them] with their first white coat” (Pamphlet). The word “cloak” transforms the coat into priestly vestments, and so the medical school surrounds the student with religious imagery in one of their most “impressionable moments.”

At these ceremonies, speakers also emphasize the commitment and responsibility of medicine, linking doctoring with the virtue of self-sacrifice and thus bolstering the construction of the doctor as a savior figure. One student explained that when he received his white coat, he realized “he would have to devote [his] intellectual capacity, time energy to the profession. I would have to adjust my lifestyle. I would have to make a number of sacrifices” (Pellegrino).

The white coat ceremony thus communicates Christological narratives to the newly inducted, marking their separation from the rest of society. Students leave behind old identities; their coats unify them. As one scholar puts it, “They are taking on a profession, a calling... This ceremony is the first stop in the ‘conversion’ of the lay person into new priestly status set apart from the laity” (Veatch). *Conversion* is a strong word, but it accurately reflects the divide between those who save and those who must be saved. Separate and sanctified, the would-be physician prepares for saviorhood.

Theologians have described Christ as a holy healer for centuries. An analysis of contemporary images of and rhetoric about the doctor, however, reveals an inversion of the metaphor: Jesus may be a sacred physician, but the physician is also a secular Jesus. The ritual of the physical examination and the symbol of the white coat as they appear in medical school ceremonies, poetry, paintings, television shows, and real-life clinical interactions layer the physician in Christological imagery. Sheathed in narratives, the doctor, no matter her own self-image, enters into a profession laden in cultural symbology that turns her from the simple healer into the sacred-scientist-savior.

C A N C E R : THE UNHOLY ENEMY

*Put on the whole armor of God, so that you may
be able to stand against the wiles of the devil.*

Ephesians 6:11

*Jesus rebuked the demon, and it came out of him,
and the boy was cured instantly*

Matthew 17:18

*“Lord, in your name even the demons submit to
us!”*

Luke 10:17

There can be no savior if there is nothing to from which to be saved. The secularization of the Christian narrative of salvation demands an enemy. In the Bible we see demons, we see spirits, we see Satan himself. In our hospitals, waiting rooms, and newspaper headlines, we see disease. Although numerous other ailments may prompt patients to cling to narratives of secular salvation, this paper focuses on the most dreaded of all: cancer. A 2006 study named cancer as America’s most feared disease, and a repeat study in 2010 found the same results, by an even greater margin (Harris). So deeply embedded is the fear of cancer in this nation’s psyche that we speak of it in pseudo-religious terms, militarizing our fight against cancer and turning the crusade into a holy war.

The History behind the War on Cancer

Human societies have wrestled with a disease called cancer since Hippocrates first named it *karkinos*, or crab, around 400 BC (Retief). However, cancer distinguished itself from other conditions and gained traction in the American consciousness in the mid-20th century, thanks to the marketing ploys of the first national cancer lobbyists. In 1943, high-powered Manhattan philanthropist Mary Lasker settled on cancer as her cause and pressured a friend at *Reader's Digest* to publish several articles about cancer screenings (Mukherjee 105). The series launched cancer into the public eye. Letters and donations poured in, and the media began to comment on the country's relationship with the disease in particularly antagonistic terms. In 1947, Newsweek spoke of the "fight to conquer cancer," and a year later, Collier's published an article called *CANCER, THE CHILD KILLER*. Yet although the press had begun to demonize cancer, the language of warfare did not become completely widespread in political and public discourse until Nixon stepped in (Patterson 143).

In the 1950s, Lasker, the same philanthropist behind the *Reader's Digest* series, took the reins of the American Cancer Society and turned it from what functioned as a small-scale Manhattan social club for physicians into a juggernaut of a fund-raising and lobbying group (Cohen 76). Lasker partnered with Dr. Sidney Farber, now known as the father of modern chemotherapy, and together they set their sights on Washington. Lasker and Farber knew that federal support would revolutionize cancer research, and so in order to place pressure on the government, they plunged into a public awareness campaign. It

was not long before the language they used to characterize their efforts began to take on militaristic undertones. In a 1954 letter, Farber referred to their campaign against cancer as a *crusade*, their devotion already resembling religious fervor against a mortal enemy (Mukherjee 115).

The root word of crusade is *crux*, Latin for *cross*. A crusade is more than just a war – it is a campaign advanced by Christian powers against a godless foe. By attaching the word to his efforts, Farber suggested that he was fighting against not just a disease, but an adversary. Mary Lasker herself represented the dichotomy perfectly when she said, “I am opposed to...cancer the way I am opposed to sin” (Bishop). Thus, from the very beginning of their anti-cancer undertaking, the crusade against cancer resembled spiritual warfare. The opponents began to crystallize: on one side stood cancer, and on the other, Lasker, Farber, and, they hoped, the rest of the American people.

Lasker and Farber wanted to approach cancer with the research strategies that prevailed in the wake of World War II but had since lost popularity among grant-giving bodies in Washington. The Manhattan Project had shown that in a matter of years, focused teams of scientists could answer the call of an explicit scientific challenge marked by timelines and targeted funding. Borrowing from the culture of coordinated military stratagems, one scientist called such directed research efforts “frontal attack” science. (Mukherjee 120). Since then, however, governmental funding had begun to favor long-term, basic scientific research. Lasker and Farber envisioned a governmental campaign that reverted to the older culture of scientific research, one distinctly militaristic in nature.

Lasker and Farber wanted to capture the attention of a nation. They needed to make a splash, and so in one of the most brilliant moves of their lobbying careers, they crafted a full-page advertisement as melodramatic as it was motivating. It appeared in print in the *Washington Post* on December 9th, 1969, and ran again eight days later in the New York Times (see figure 1). The image spurred a nationwide crusade against cancer that has steadily gained ground since. It suggested that cancer was not only the deepest fear of the American people, but also their greatest foe. By conceptualizing the disease as a threat to the nation, Lasker saddled the White House with the responsibility to defeat it – just as the government ought to wage against forces of evil abroad, so too must it fight the terror within. Six words, printed in bold across the page, marked a transformation in cancer’s relationship to the American public: *Mr. Nixon: You can cure cancer.*

The subtext of the advertisement begins,

If prayers are heard in Heaven, this prayer is heard the most:

“Dear God, please. Not cancer.”

Still, more than 318,000 Americans died of cancer last year.

This year, Mr. President, you have it in your power to begin to end this curse.

As you agonize over the Budget, we beg you to remember the agony of those

318,000 Americans. And their families. “

By beginning with a prayer, Lasker and Farber have acknowledged the link between the threat of disease and the search for salvation. The ad begins, then, with deep desperation. The American people beg, “Dear God, please. Not cancer,” and according to Lasker and Farber, this is the prayer they pray the most. By later characterizing cancer as

a “curse” from which we must plead for divine intervention, the advertisement names cancer as a deep and ungodly evil – a satanic figure of sorts. Instead of salvation from Satan’s grasp, the American populace prays for salvation from cancer. Cancer, then, is wicked. It is ominous; it is deadly. The poster’s words themselves fall prey to disease. Dividing cells burse out of the edge of “cure” and “cancer” and spread, leaving disintegrating letters in their wake. Torn apart from the inside out, the skeletons of what was once an *e* and an *r* herald the destruction to come.

The ad suggests that the prayerful public begs God to spare them from cancer and then turn to scientific research for salvation. Yet cancer is not simply the enemy of the devout; it is also the enemy of the nation itself. The text moves immediately from a plea to God to an address to Nixon without a clear transition, thus infusing a request for government intervention with spiritual desperation. Salvation from cancer may ultimately come from God, but it is Nixon who must begin to end the “curse” – the fight against cancer is battle both secular and sacred. The advertisement uses the language of unholy horror to describe the disease, but it then merges the rhetoric of evil with the imagery of warfare when it lists statistics like casualties in a war: “318,000 Americans died of cancer last year”, and “one in six Americans now alive...will die of cancer unless new cures are found.” The advertisement thus melds the metaphors of satanic attack and secular war, turning the war on cancer into a holy one.

Body counts then give way to a battle cry for budget reform: “Americans can do this.” The quest against cancer, then, is not only pseudo-religious, but also patriotic. Prominently displayed at the bottom of the ad is the name of Lasker’s lobbying group: The Citizens Committee for the Conquest of Cancer.” The message is clear: the nation’s

people need the President to take action. Plagued by crisis, the country cries out for battle plan. In the ultimate plea to patriotism, the ad later asks, “Why don’t we try to conquer cancer by America’s 200th birthday?”

Figure 1: *Lasker’s full-page ad turned her battle against cancer into a nation-wide war.*

Mr. Nixon:

You can

cure

cancer



If prayers are heard in Heaven, this prayer is heard the most:
“Dear God, please. Not cancer.”
Still, more than 318,000 Americans died of cancer last year.
This year, Mr. President, you have it in your power to begin to end this curse.
As you agonize over the Budget, we beg you to remember the agony of those 318,000 Americans. And their families.
We urge you to remember also that we spend more each day on military matters than each year on cancer research. And, last year, more than 21 times as much on space research as on cancer research.
We ask a better perspective, a better way to allocate our money to save hundreds of thousands of lives each year.
America can do this. There is not a doubt in the minds of our top cancer researchers that the final answer to cancer can be found.
Already, 4 out of about 200 types of cancer can be cured with drugs. And 37 other drugs will cause temporary remission in 17 other types of cancer.
Dr. Sidney Farber, Past President of the American Cancer Society, believes: “We are so close to a cure for cancer. We lack only the will and the kind of money and comprehensive planning that went into putting a man on the moon.”
Why don’t we try to conquer cancer by America’s 200th birthday?
What a holiday that would be! Cancer could be then where smallpox, diphtheria and polio are today—almost nonexistent.
If you tell us, Mr. President, this will happen:
One in six Americans now alive, 34,000,000 people, will die of cancer unless new cures are found.
One in four Americans now alive, 51,000,000 people, will have cancer in the future.
We simply cannot afford this.
Our nation has the money on one hand and the skills on the other. We must, under your leadership, put our hands together and get this thing done.
Surely, the war against cancer has the support of 100% of the people. It is a war in which we lost 21 times more lives last year than we lost in Viet Nam last year. A war we can win and put the entire human race in our debt.

To the public, cancer patients, their friends and relatives:
Write or wire the President, urging him to put more funds behind cancer research. Or, please use this coupon.

Dear Mr. Nixon:
Cancer research needs more funds. Please provide them in your 1973 budget. Please.

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

Mail this coupon to: The President
The White House
Washington, D.C.

CITIZENS COMMITTEE FOR THE CONQUEST OF CANCER
888 United Nations Place, New York, N.Y., Science-Goth, M.D., Executive Paste, Co-chairman

Remember, however, the timing of the advertisement. It is 1969, and the country is already mired in war. Why fight another one? The advertisement already has an answer:

Surely the war against cancer has the support of 100% of the people. It is a war in which we lost 21 times more lives last year than we lost in Viet Nam last year. A war we can win and put the entire human race in our debt.

This is not a war like the one we are already fighting, the ad seems to suggest, for this is a war without controversy. The war on cancer “has the support of 100% of the people.” Here is a conflict even deadlier than Vietnam, one in which we are the clear victims, one in which we already have a stake. One sentence compares the number of cancer victims to the number of Vietnam victims; the next calls the fight against cancer “a war we can win.”

Lasker and Farber get it: in the midst of a protracted, embarrassing, and divisive fight overseas, the nation’s people are hungry for heroism. They want to win a war that has not only a political meaning, but also a moral, even spiritual one. With enough of our class American can-do attitude, science can triumph over cancer and good can triumph over evil. By beating back a hellish adversary, America will emerge from the holy war victorious. The conclusion is clear: when we “win the war,” then we “put the entire human race in our debt.” In light of the good-evil dichotomy in anti-cancer rhetoric, the language of debt echoes the language of Christological salvation. Americans can cure cancer for all mankind. We can be the saviors; we can take on the burden of cancer’s

complexity and relieve humanity of what plagues it. America, with its smart science and daring doctors, can be Jesus.

Mary Lasker understood the power of language. She knew how to fashion a unifying war that served as a counterpoint to a divisive one. Yet she understood not only how to harness political unrest, but also how to ride the wave of scientific progress. The advertisement arrived at the perfect time. America had put a man on the moon only months before, launching a new season of both scientific optimism and national pride. As *Time* magazine reported that year, “Apollo 11 was...a shining reaffirmation of the optimistic premise that whatever man imagines he can bring to pass” (Mukherjee 178). Mary Lasker wanted the nation to imagine an end to cancer, and she was certain that federal funding would bring it to pass. She harnessed public confidence in the powers of science, and began to refer to anti-cancer efforts as the conquest of “inner space,” as opposed to “outer space” (179). America had already put its flag on the moon; the time had come to put its flag on the body. In lobbying for governmental support, Lasker began to speak of a “moon shot” for cancer. If we can put a man on the moon, the thinking went, then surely we can cure cancer here on earth. Thus, the energy of space exploration, along with the anxiety of Vietnam, became another rhetorical pressing point for Lasker’s lobbying efforts. Linked to the nationalism that saturated the space race and contrasted with the moral ambiguity of the Vietnam war, the war against cancer became a part of the national identity.

The 1969 advertisement, then, marked a new era of cancer’s relationship to the public. It assumed that America’s people wanted to cure cancer – it was the prayer they prayed the most, after all – and advocated on their behalf. Cancer skyrocketed into public

consciousness. In 1968, the *New York Times* printed 289 articles that contained the word *cancer*. In 1969, it printed 562, and in 1970, that number rose to 804. Cancer was everywhere – the 1970 movie *Love Story* addressed leukemia, in 1971, *Brian's Song* dealt with testicular cancer, and in 1973, *Bang the Drum Slowly* examined Hodgkin's lymphoma. Cancer was America's enemy, and Nixon knew it.

With the 1972 election looming and a country mired in a seemingly endless war in Vietnam, Nixon was eager to win hearts. As the *Chicago Tribune* pointed out, "If Richard Milhous Nixon...can achieve these two giant goals – an end to the war in Vietnam and defeat of the ravages of cancer – then he will have carved for himself in the history of this nation a niche of Lincolnesque proportions, for he will have done more than put a man on the moon" (Mukherjee 187). Moreover, Nixon was already skeptical of the current state of scientific research. Often characterized as impatient, ambitious, and driven, Nixon had very little patience for the uncertainty of open-ended scientific research. He complained that when it came to managing science, scientists didn't "know a goddamn thing" (183).

It didn't take much, then, for Lasker and Farber to convince Nixon's government to take on the fight against cancer. In 1970, at Lasker's suggestion, Nixon formed a commission to discuss the future of cancer research (Rettig 1). It was at this point that warfare-based cancer rhetoric began to seep into the language of Capitol Hill. Farber served on the commission formed by Nixon, and told legislators to use the military metaphor intentionally; the government, he argued, ought to hold progress against cancer to the same standards as a military assault, with the same urgency and the same fervor (3). In response, Senator Yarborough, who introduced the resolution that prompted the

National Cancer Act, stated the importance of “mak[ing] the conquest of cancer a national goal of the highest priority” (2). In the winter of 1970, the panel released a report entitled *The National Program for the Conquest of Cancer*. The language of militarism was here to stay.

The report prompted the National Cancer Act, signed into existence by Nixon in 1971. The act commissioned the National Cancer Authority and defined its mission as “the conquest of cancer at the earliest possible time” (Rettig 3). Devoted solely to the funding and management of cancer research, the NCA merged a sense of nationalistic duty with scientific optimism. It’s no wonder, then, that the Authority has been called a “NASA for cancer” (Mukherjee 184) Nixon granted the institute incredible autonomy; instead of placing it under the NIH, as was the case with similar agencies, Nixon appointed the director himself. He wanted to pin the NCA to his name and paint it into his public image.

Nixon cemented the military metaphor in the speech he gave when he signed the act. He never referred to anti-cancer efforts as a war, but he did call it “an intensive campaign to find a cure for cancer” and noted, “more people each year die of cancer in the United States than all the Americans who lost their lives in World War II.” The language of campaign and conquest turned cancer research into a quest for a cure, a clear struggle between good and evil. He likened the war on cancer not to his own war in Vietnam, but to World War II, often glorified in his era and ours as the “good fight.” Journalist Tom Brokaw, after all, referred to its soldiers as “the greatest generation,” characterizing WWII as the fight of selfless soldiers against evil abroad (Brokaw). If World War II was the good fight of the early 40’s, then cancer would serve as our

nation's next epic battle. Once again, Americans were the earnest underdogs, and once again, their determination and innovation would surely defeat the evil superpower.

Further underscoring the quasi-religious themes in the war against cancer, Nixon called the National Cancer Act a "Christmas gift to the American people" (Rettig 2). Indeed, current-day historical literature still mentions the Christmas theme of the act; various articles begin a description of the act with, "Two days before Christmas in 1971..." (Vasella 30, Disparities 234) The birth of the National Cancer Authority coincided with the birth of Jesus, a holiday that celebrates the promise of salvation. This was Nixon's Christmas gift to the nation: a piece of legislation borne of a determination to conquer that which had the power to kill. Just as coming of Christ signaled the conquest of death, the arrival of the NCA heralded the conquest of cancer. The legislation launched a war laden with the language of righteousness, just as Saint Paul proclaimed in 1 Corinthians 15:54, the nation hoped to turn to cancer and cry out, "Death has been swallowed up in victory."

President Nixon was hardly the first to link the language of warfare to cancer, but he did make it official. The National Cancer Act was the first expansive and extensively funded effort against cancer in American history. That the government branded it in the vocabulary of war would shape perception of cancer for decades to come.

For Nixon, the war on cancer thus served as a convenient opportunity to unify the public behind wartime rhetoric and, ideally, distract from the actual war that plagued his public image. The metaphor of holy war, then, did not emerge from nowhere; it was a calculated campaign fashioned by lobbyists to win the hearts of the American people and was then taken up by Nixon to distract from his failures in Vietnam. None-too-subtly,

Nixon stated in his speech before signing the act that he hoped that “in the years ahead ... we may look back on this day and this action as being the most significant action taken during this Administration.” He channeled militaristic language into a fight that did not actually involve the military, thus pouring political capital into a campaign with which no one could argue. It was cancer he was fighting against, after all, and so if the American people prayed, “Dear God, please – not cancer,” Nixon had an answer.

The Metaphor in Contemporary Discourse

The rhetoric of warfare did not resign with Nixon. Long after the Vietnam War came to a close, pseudo-religious military metaphors continued to characterize discussions of cancer. If anything, a temporary end to warfare abroad allowed cancer to assume the cultural anxieties that once surrounded actual military engagement. On the subject of generational fears, columnist Ellen Goodman wrote in 1978, “When I was growing up in the 1950s, it was The Bomb. We seem to have dropped our bombphobia....Cancer now leads this macabre hit parade. The middle-sized children I know seem to think that death comes not with a bang but with a tumor” (Milwaukee Sentinel, September 13th, 1978, qtd in Mukherjee 182).

The war marches on. A 1994 *Time Magazine* cover promised “Hope in the War Against Cancer.” The 2003 6th edition of *Cancer Medicine* explains that in America, the “conquest of cancer” became a “national goal” (Holland-Frei). In 2009, the *New York Times* ran a series on “The Forty Years’ War,” and in 2011, the renowned journal

Science devoted an issue to commemorating the 40th anniversary of the “Cancer Crusade.”

Mass media loves its metaphors, and so contemporary journalism not only reports on the “war on cancer,” but also defines its players. Obituaries honoring the fallen often report a “long fight with cancer,” and those who make it out alive identify as “survivors” like war-weary civilians emerging from the rubble. So entrenched is survivor terminology that the National Cancer Institute has a division called “The Office of Cancer Survivorship.” When Senator Kennedy received a cancer diagnosis, the media called him a “fighter,” and various popular women’s magazines have profiled women they deem “breast cancer warriors” (Toolbox, De Gersdoff). The war drafts doctors too, of course, sometimes referred to as “foot soldiers” (Lobos).

The military metaphor not only applies to the fighters, but also to the mechanisms of attack. Rhetoric often frames the progression of the disease in terms of breach and assault. As a *Newsweek* article put it, “in some cancers, rogue cells break away from the primary tumor...and make their insidious way to distant organs.” The language of invasion is so ingrained that we cling to it even to our own detriment. Michael Sporn, a professor at Dartmouth Medical School, calls the metaphor “absolute nonsense” (Leaf). Cancer occurs long before invasion, and our adherence to invasion rhetoric might actually prevent early treatment. Some scientists argue that our focus on large-scale assault prevents doctors and researchers from paying attention to precancerous cells that have yet to “invade.” Though military metaphors may not apply to their body, people in early stages of carcinogenesis are not healthy and should not be treated as such. Yet treatment still focuses on attacks on cancerous cells rather than prevention before the fact.

“It’s what I was taught in medical school,” Sporn explains, “It’s not cancer until there’s invasion.” The language itself, then, shapes the way doctors and patients approach interventions, obscuring our vision and clouding our judgment.

In response to invasion, the forces of resistance rely on militaristic assault. Sometimes, the metaphor becomes material: the mustard gas used in World War II, which attacks white blood cells in bone marrow, became the chemical basis for one of the first forms of chemotherapy (NPR). The metaphor even delves into the complexities of military strategies. Of a recently released medication, a 2011 *Time* magazine piece explained, “unlike chemo and radiation which use carpet-bombing tactics that destroy cancer cells and healthy cells alike, these new medicines are like a troop of snipers, firing on cancer cells along and targeting their weakest links” (Lemonic) Warfare rhetoric also serves as a useful tool to motivate research and funding. A 2011 CNN piece urged the country to “recommit to the anti-cancer effort,” arguing, “in war, more than 200,000 avoidable deaths in one year is an unacceptable outrage. In the war on cancer, it is just forgotten” (Leaf).

From TV screens to magazine covers, the war on cancer issues its dispatches. The metaphor turns the hospital into the front lines and the body into a battle zone. Patients are fighters and survivors, doctors are foot soldiers, and the coveted cure for cancer, if it were to ever come about, would be the ultimate victory against our mortal enemy. The “war on cancer” language of Nixon’s era has made it easy to conceive of cancer as our evil nemesis, and like any cultural adversary, cancer is a foe of multiple faces. In some instances, the warfare metaphor has morphed for a modern age. A 2008 *Newsweek* piece called cancer’s death toll “equivalent to three jumbo jets crashing and killing everyone

aboard 365 days a year” (Begley). The article echoes a 2004 piece in *Fortune Magazine*, which quotes a cancer researcher who explained, “It is as if one World Trade Center tower were collapsing on our society every single day.” The article ends with a sense of indignation and urgency. If cancer claims our country as a terrorist hijacks a plane, then “why aren’t we winning this decades-old war on terror – and what can we do now to turn it around?” (Leaf). Similarly, Fox News coverage of a 2010 breast cancer fundraiser declared, “we’re going to wage war against a terrorist called cancer,” and in 2008, *The Economist* printed a 2008 piece on cancer called “The root of all evil?” which labeled cancer “the scourge of modern humanity” and discussed its molecular “hijacking” mechanisms. The piece was published on September 11th. Cancer, then, has adopted the primordial fears of invasion and attack unique to each epoch – it captures every generation’s understanding of good versus evil. In Nixon’s time, cancer was the WWII dictator. In ours, it is the merciless terrorist. Our terms of war have changed, and cancer in kind morphs into the demon of each era.

The war on cancer manifests itself in not just journalistic articles, but visual media as well. For another glimpse at this nation’s understanding of evil, we can look towards *Time Magazine*’s ‘X’ cover series, which *Time* itself describes as “a gallery of America’s most hated enemies” (Techland). Ever since the death of Hitler in 1945, *Time* has marked the demise of the most infamous of public figures by crossing their faces off in red ink on the front cover of its magazine. The gallery includes the likes of Saddam Hussein, Osama Bin-Laden, and al-Qaeda member Abu Musab al-Zarqawi. On May 18, 1998, *Time* published the next addition to the X cover gallery – this time, the red X ran through the word *CANCER*, an attempt to mark significant progress in cancer research (Popp 206).

Now classified with terrorists and dictators, the red X signals that cancer is an enemy “Hitler-esque in its magnitude of evil” Thus, the X serves as shorthand to brandish cancer as an “enemy without conscience, striking indiscriminately and without warning” (206).

Figure 2: *The covers of TIME magazine track the nation’s greatest enemies.*



The connection between cancer and Hitler has cropped up before. When describing politician Philip Gould’s struggle with cancer, one reporter called the cancer *Adolf* and Gould *Churchill*. In the likeness we see a continuation of the WWII metaphor to which Nixon clung, and for the same reasons – linking cancer to the Second World War casts the fighter as the courageous hero and the enemy as the morally depraved. This struggle becomes black and white, good versus evil, holy versus wicked. If cancer is Hitler (or Saddam Hussein, or Osama Bin-Laden, as the *Time* covers suggest), then cancer in the public consciousness is none too far from hell.

The depiction of the struggle against cancer as a fight between opposing forces, moral versus corrupt, imbues the war on cancer with pseudo-religious undertones. Hitler and Bin-Laden have both been called the personification of evil; as the *Time* covers

suggest, so too is cancer. At its very inception, Dr. Sidney Farber called the war on cancer a crusade. The *Time* covers thus speak to what he knew from the very beginning: the battle we wage against the disease is not just about conquest – it is also about redemption. When we win the war on cancer, we win a war against evil. We rid our country of a biological terrorist and prove that life can prevail. This is spiritual warfare made secular – made medical, in fact.

Because the way we speak of cancer recalls the way we speak of religious evil, references to the underworld abound. One reviewer of Gould's book described the author as "a brave man who crawled through hell" and who sensed the "apocalyptic immensity" that cancer had assumed in society. *Hell, apocalypse* – these are terms that plant us firmly in the realm of the religious. The war on cancer, then, is a war waged against demonic forces. War rhetoric is thus particularly significant in light of the cultural construction of the doctor as savior. By depicting cancer as a mortal enemy, we create an antichrist against which modern medicine can launch a pseudo-spiritual, pseudo-secular battle.

The holy war analogies of the cancer battle align with particular Christian theologies. Christianity is not a militaristic religion – Jesus advocated turning the other cheek, after all – but war imagery runs throughout the Old and New Testaments to describe the tension between good and evil. Thus, we can speak of "putting on the armor of God," or sing the opening bars of the hymn "Onward Christian Soldiers" (Ephesians 6:10-18). There is no inherent Christian narrative in a "war on cancer," but because modern discourse about the "cancer crusade" characterizes cancer as an unholy enemy and turns the fight into a battle between good and evil, cancer can become the Satan from whom we must be saved.

Understanding the war against cancer as a holy war explains the pseudo-religious references that often accompany stories of healing. A Newsweek article explains, “nowhere is Miracle Mania more rampant than in stories about cancer,” noting that media hype around “magic bullet cures” points to societal hunger for the miraculous (Callahan 67). Spiritual warfare requires divine intervention, so it seems appropriate that the *New York Times* has discussed the perceived roles of both mammograms and leukemia-related genetic testing as “saviors.” Despite its heavy religious connotations, “savior” isn’t exactly a term used sparingly, and is bandied about in advertisements and blog posts to describe various treatments such as robotic prostate surgery and anti-cancer nutrition supplements (iOne, Parker-Pope, Watzman).

The metaphor of spiritual warfare becomes even more apparent when we examine repeated fire-and-brimstone references to cancer in public discourse. Patients often describe having cancer as “hell,” and one article called one of the molecular mechanisms of cancer proliferation “the antenna from hell” (Begley). Fire imagery abounds in popular portrayals of cancer. In describing a patient, one doctor explained that cells from an original lung tumor “were smoldering in other places the whole time” (Kim). In a separate article, another physician described his strategy for cancer prevention: “Let’s aggressively find those members that have been smoldering in many of us for years – and douse them before they become a full-fledged blaze” (Leaf). The language likens cancer to some fiery underworld, one in which sorrow and suffering reign. A University of California graphic offers us a glimpse into the battle (see figure 3). Note the army-style typeface, the red hues, and the depiction of the cancer cell as a menacing monster

bursting onto the scene. The fight against cancer plunges us into such an underworld – war, after all, is hell.

Figure 3: *Current references to the war on cancer continue to draw upon imagery both militaristic and demonic.*



Yet cancer in contemporary discourse is not just an experience. It is also an agent, an actor to which we can assign traits. Personifications paint cancer in a ghastly light; in the mid-20th century, politician Bruce Barton called cancer “something more terrible than words can describe,” and shuddered at the “teeth and claws of the awful thing.” (Patterson 160). A 1989 book on cancer is titled “The Dread Disease,” and rightly so – although every illness can incite fear, cancer appears to prompt a particularly potent

horror (Patterson). Images from the 1940s and 1950s depict cancer as a lurid crab⁴, an amoebic monster, or a glaring skull (see figure 4). The crab-like skeleton shown on the *Time* cover captures the connection between the medical and the satanic; with slitted eyes, menacing claws, and bared teeth, the symbol of cancer looks like a demon from hell. Pictures from today perpetuate the characterization; a drawing in the *Economist* depicted cancer as a mass of skulls scowling from a petri dish (see figure 5).

Even the realm of scientific rationalism can play into sinister characterizations; the Springer book series “Research and Perspectives in Alzheimers’s Disease” published a 2011 book called, “Two Faces of Evil: Cancer and Neurodegeneration” (Curran). Cancer exists as a manifestation of wickedness itself, leering out at us as deformed monsters or demonic skulls from the pages of the press. The disease has captured our cultural imagination, which places it squarely on one side of the line between the noble and the nefarious. It is no wonder, then, that the Fox Chase Cancer Center in Philadelphia offers its patients wristbands reading, “Love versus Cancer” (Hoke). The catchphrase suggests that they are opposing forces, an unquestionable good juxtaposed against an unquestionable horror. After all, if the Springer book series is to be believed, evil has faces, and at least one of those faces is cancer.

⁴ The word “cancer” comes from the Greek word for crab: *karkinos* – the same word, in fact, from which the zodiac symbol derives. Hippocrates gave cancer its name, most likely because advanced tumors that protruded from the skin reminded him of the crustacean (Markel).

Figure 4: *Various personifications of cancer as an inhuman and unholy monster.*

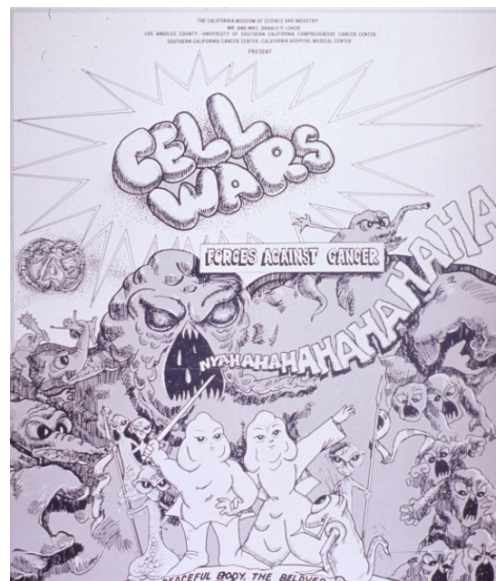
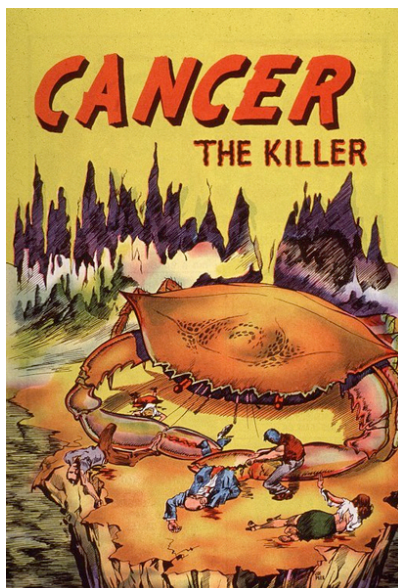
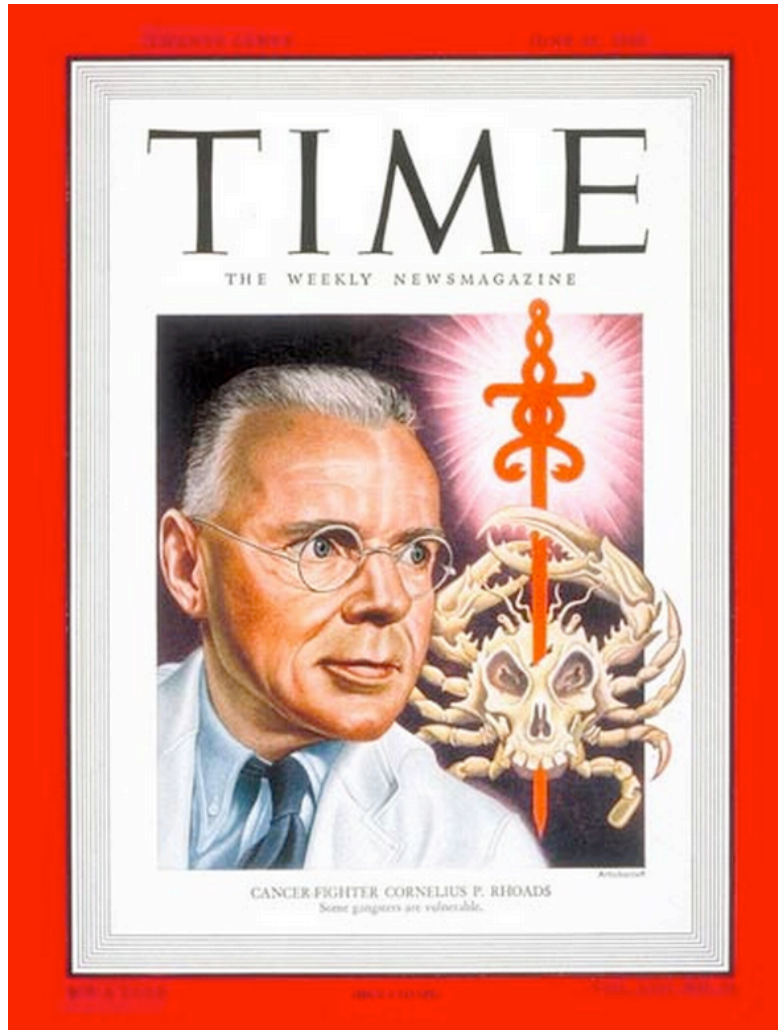


Figure 5: *A mass of skulls glare from a petri dish in this drawing, first featured in The Economist*



Cancer is not simply a monstrous disease to have – it is *itself* a monster. War is hell, and cancer is the devil. Contemporary rhetoric assigns a moral agency to the disease that transcends its existence as a biological condition, thus allowing us to demonize it. A *Newsweek* article explained that “cancer cells are like brilliant military tacticians: when their original route to proliferation and invasion is blocked, they switch to an alternate, marching cruelly through the body” (Begley). Thus, it’s not that cancer is cruel – it’s that the cancer, as a “brilliant military tactician,” has made the decision to be cruel. Perhaps cancer even enjoys its cruelty, as one BBC show suggested when it called cancer nothing short of greedy. “Rogue cells,” it explained, “like their power, and they’re getting more of it every day” (Addicted). To some, cancer even exists as a betrayal, one of the most reprehensible of moral crimes. A corruption of cells, a perversion of genes, a treachery of our own body – cancer is not a microbe we can blame on some external vector, but

instead a product of our own molecular makeup. Thus, one CNN article calls cancer “a cell that went berserk,” and another refers to cancer cells as “rotten” (Robert, Leaf). One book discussing cancer and society is called *Betrayed by Nature: The War on Cancer*” (Hesketh). We can thus imagine cancer as good-cells-gone-bad, driven to depravity in a Lucifer-like quest for power.

Thanks to Mary Lasker, Sidney Farber, and Richard Nixon, our struggle against cancer is a war. Yet thanks to our cultural imaginations, our moral dichotomies, and our deep-seated fears, it is not just any war – it is a holy war, a battle against the Beelzebub in our bodies. From the language of hellish warfare, the need for salvation emerges. To counter cancer, we need a savior. The secularized Christian narrative in healthcare has thus begun to fall into place; when cancer is our unholy enemy, we turn to the physician for salvation.

I L L N E S S : A SIGN OF SIN

We are all infected and impure with sin.

Isaiah 64:6

Let us cleanse ourselves from every defilement of body and of spirit, making holiness perfect in the fear of God.

2 Corinthians 7:1

Jesus said to them, "It is not the healthy who need a doctor, but the sick. I have not come to call the righteous, but sinners."

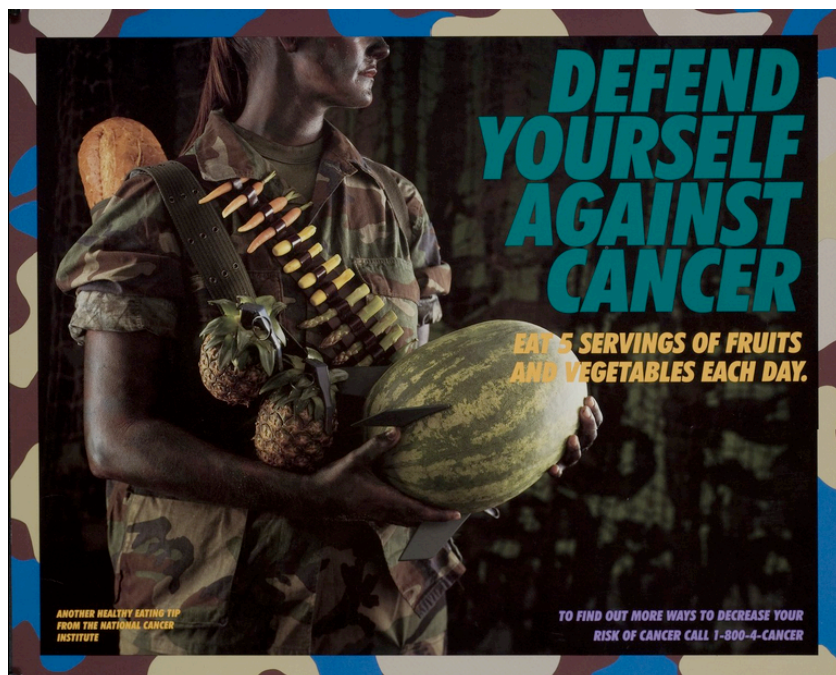
Mark 2:17

Though the doctor may be our savior and the cancer our mortal enemy, we can find one last crucial piece of the Christian narrative in our contemporary understanding of health. Christ may offer humanity salvation from a hellish end, but humans need salvation in the first place because of their sin. Christian tradition often likens sin to a sickness, but the disease prevention movement that began in the 1970s reverses the metaphor; if good health habits serve as signs of good character, then sickness itself becomes a sin.

When it comes to health, America is obsessed with prevention. Cancer is no exception. In 2005, the *New York Times* published a five-part series called "Preventing Cancer," Oprah Winfrey's website features a page devoted solely to "breast cancer

awareness and prevention,” and “The Dr. Oz Show” on CBS has devoted numerous episodes to cancer prevention. Amazon.com boasts bestselling books with titles like *The Anticancer*, *The Cancer Prevention Diet*, and *Foods that Fight Cancer*, the last two recommended by Lance Armstrong’s LIVESTRONG website (Servan-Schreiber, Kushi, Beliveau). The government echoes the sentiment: “Eat your way to good health!” one National Cancer Institute poster proclaims. Another reads “DEFEND YOURSELF AGAINST CANCER,” and features a soldier in a battle zone, clutching a watermelon and sporting a bullet strap covered in vegetables, two pineapples hanging like grenades from her side (see figure 1). The militaristic imagery prevails in the war against cancer, and as the poster suggests, the agency is ours; armed with carrot sticks and asparagus, it is up to us to defend ourselves against the enemy.

Figure 1: *A poster printed by the National Cancer Institute places the power to prevent cancer in our hands*



Privileging individual behaviors as a primary mechanism of disease prevention is not a new idea. The cultures of ancient Greece and Rome emphasized healthy living practices, and societies since then have believed to varying degrees that the individual possesses at least some measure of power over her personal health (Minkler 121). Notions of individual responsibility have waxed and waned in the United States, gaining traction in the late 1700s and then in the late 1800s with the physical hygienism movement, which understood behaviors that they believed to constitute “good living” to be not only a prerequisite to good health, but also a basis for both personal and social redemption (Gillick 369). Yet advances made after the advent of germ theory led to an emphasis on sanitation, immunization, and other public health measures (370). The prevalence of antibiotics and an increasing awareness of the mechanisms of contagion placed responsibility for illness in a germ-infested world and a nation-state that must intervene to protect its citizenry from contaminated water sources and manure-covered streets. It was no longer the individual who was to be held accountable for illness, but the government.

Then, about a century after the physical hygienism movement, the 1970s witnessed a resurgence in an emphasis on personal responsibility in health. For all the advances of germ theory, science had failed to eliminate high-profile diseases like heart disease, stroke, and, yes, cancer. Nixon’s National Cancer Act, despite its noble vision, encountered a firestorm of criticisms in the years after its passage; even with a glut of federal funding, it soon became apparent that a cure to cancer was nowhere in sight (Salecl). Moreover, a preponderance of epidemiological evidence demonstrated clear

links between health behaviors and illness (Gillick 379). More and more, the American people realized that medical innovations would not make disease disappear, and so onus shifted once more to the individual.

Scientific research began to point to guidelines for the prevention of cancer and other diseases. Yet it was not only the evidence that prompted Americans to cling to prescriptions of prevention; an emphasis on behavior change also drew its energy from a nation desperate for a stronger sense of its moral framework. Muriel R. Gillick, Mellon Research Fellow at MIT and physician at Massachusetts General Hospital, argues that in the 1970s, advances in biomedical thinking around prevention accompanied a recommitment in American society to traditional national values (375). The Watts riots, the assassinations of King and Kennedy, My Lai Massacre, the Kent State shootings – crisis after crisis left the country with a sense of what a *Fortune* magazine writer had called in 1968 a “deeper and more general moral sickness in contemporary society” (375). It was in the midst of such despondency that Nixon won two elections by appealing to the “great silent majority,” imagined as the quiet, hard working, tax-paying middle-class Americans who found their values of individual enterprise and order under siege by protestors, rioters, and criminals (Lassiter xiii). A vote for Nixon thus became a vote for virtuous living. The campaign was brilliant; the chaos of the 1960s had left the country hungry for a value system it could rely upon. America cried out for transformation and clung to the hope that better living would lead to a better country.

The rise of preventative health discourse thus appealed to a nation hungry for virtuous lifestyles and universal values. With American notions of voluntarism, decentralization, and individual autonomy in mind, the belief that individuals are

responsible for their own health began to sound downright patriotic (Neubauer 215; Minker 121). With a recommitment to personal wellbeing, the American people answered the challenge John F. Kennedy posed in 1960 when he observed in *Sports Illustrated* that “an increasingly large number of young Americans who are neglecting their bodies...are getting soft. And such softness on the part of individual citizens can help to strip and destroy the vitality of a nation.” To keep our country great, he argued, we must be “willing to work for the physical toughness on which the courage and intelligence and skill of man so largely depend (Kennedy). It is through healthy living, then, that we become admirable – and if its citizens are admirable, then so too is the country.

Like it did with the war on cancer, federal action would cement and perpetuate larger societal perceptions of health. In 1976, congress created the Office of Disease Prevention and Health Promotion, which to this day offers dietary guidelines and physical activity recommendations. A year later, the senate produced a report titled *Dietary Goals for the US*, which operated under the assumption that “the kinds and amounts of food we consume may be the major factors associated with the causes of cancer, circulatory disorders, and other chronic disorders (Le Fanu 283). Finally, the Surgeon General released a landmark report in 1979. Titled *Healthy People*, the publication announced that individual behaviors served as the primary causes of illness. Called “the manifesto of a second public health revolution,⁵” the report announced, “We are killing ourselves by our own careless habits” (Gillick 383). Though the publication

⁵ The first public health movement began as a result of the 1848 Public Health Act in Britain, which established principles in state intervention in public health, including maintenance of the water supply, etc. (Hamlin 587).

acknowledged the role of larger environmental contributors to disease development, at its core, *Healthy People* held the individual accountable for personal health (Goodman 27). With responsibility clearly allocated, the Surgeon General had essentially privatized personal health problems.

The notion of individual responsibility for health stuck, and three decades later it manifests itself in bookstores and magazine covers, television shows and Oprah's website. In 1987, philosopher and ethicist Daniel Wikler observed, "That individuals are responsible for staying healthy is becoming a truism of health promotion and health policy" (Lowenberg 319). Today, as a nod towards the 1979 report, the Office of Disease Prevention and Health Promotion has drafted 10-year national health objectives it calls *Healthy People 2020*, thus demonstrating that the federal commitment to prevention rhetoric remains unchanged.

As the TV show *The Biggest Loser* enters its 14th season, as "22 disease-fighting superfoods" make national NBC news, as study after study uncovers more linkages between lifestyle and longevity, disease prevention campaigns build momentum. In 2007, the American Cancer Society launched "The Great American Health Challenge," which encouraged individuals to take control of their cancer risk by asking for screening tests, engaging in physical activity, eating a well-balanced diet, and abstaining from smoking. The press release announces that "healthy behaviors can prevent at least 50% of cancer deaths," and that the campaign will "motivate Americans to take action to reduce their cancer risk" (Steinmark). The power is in the hands of the people, it seems to suggest – the fate of your body is for you to decide.

Preventative health messages have a subtext. They are laced with a hidden story about illness and responsibility, one founded in an American commitment to the concept of self-determination. When discussing the advent of personalized, genome-based medicine, Dr. Olopade, a research scientist who won a 2005 MacArthur fellowship for research on breast cancer gene expression, stated, “I think our society is individualistic enough for people to take personal responsibility for their own health” (Vanchieri 343).

Yet a cultural commitment to personal responsibility has its dark side. It plays into what sociologist Dr. June Lowenberg at the University of Washington calls “the ideology of choice,” which suggests that because individuals choose their behaviors, they indirectly choose their disease (319). Well-meaning ambitions to prevent disease by living well unintentionally generate an alternate narrative for those whose ambitions fail them: illness means you have lived poorly.

The language of prevention easily morphs into the language of fault. As one newspaper columnist put it in 2012, “How can we cure cancer when it’s lifestyle that’s to blame?” (Independent). When an individual’s behavior is at fault, the next logical step assumes the individual herself is at fault as well. In a 1993 paper called, “Why do the victims blame themselves?” sociologist Mildred Blaxter uses survey data and qualitative interviews to demonstrate that many people, including patients themselves, associate poor health with poor willpower (Radley 124). Willpower – that great American quality, that puritan virtue, that pull-yourself-up-by-your-bootstraps mentality – reserves sacred space in our national value system. To lack willpower is to lack a fundamental moral necessity. As one Newsweek article put it, “Only in America – with our stubborn belief in the miraculous possibilities of medical progress – is there a tendency to liken fatal disease,

the work of impersonal nature, to sin, the result of human choice” (Callahan). No matter how much sympathy we have for the sick, national values of individual responsibility encourage us to understand disease as a product of personal failings – as a sign of some sin, in fact. The narrative may appear in other cultures, but it proves particularly dominant in here; “only in America” would a commitment to the virtue of self-determination prompt us to confuse sickness with sinfulness.

Whether explicitly or implicitly, the way our country so often talks about health perpetuates a particularly puritan notion of morality. The righteous are those who run 5Ks, or eat kale, or wake up at 5:00 for early-morning yoga – they are Benjamin Franklin’s “healthy, wealthy, and wise.” In contrast, the sinful are those who give in to poor health behaviors – the next cigarette, the second donut, the day spent on the couch; they are the “soft Americans” of John F. Kennedy’s essay. As David Levin observes in his book *Pathologies of the Modern Self*, “Good health has become a new ritual of patriotism, a marketplace for the public display of secular faith in the power of the will” (Minker 128).

Such “secular faith” in willpower can cause us scorn those who fall short of righteousness; sickness, the doctrine goes, betrays a lack discipline and weakness for indulgence. As Kennedy’s logic suggests, because they lack so-called American virtues like independence and initiative, those who fall ill fall short of the national ideal. The best kind of American is the strong and healthy one, the citizen who cultivates the finest version of herself and her body. Thus, by emphasizing the connections between individual behavior and health, contemporary discourse on disease prevention has produced what Dr. Marshall Becker, former editor of *Health Education Quarterly*, calls a

“New Morality.” “Being ill,” he explains, “is redefined as ‘being guilty.’ The obese are stigmatized as ‘letting themselves go.’ Smokers ‘have no will power.’ Nonaerobics are ‘lazy.’” (Becker 1993, 4). Not everyone makes such assumptions, of course, and the construction of guilt is simply one narrative among many surrounding the consequences of disease – yet it is still a familiar one.

While our health-related construction of morality heaps accolades upon the healthy, it also abandons the ill. The literature demonstrates time and time again that those with cancer often blame themselves for their illness, attributing it to personal behaviors like diet, emotions, or stress (Friedman). A 2011 study, for example, found that over 25% of men with colorectal cancer reported that it was at least ‘a little true’ that they were to blame for their illness” (Phelan). The percentage increases for cancers linked to particularly stigmatized activities, like smoking; lung cancer patients experience greater feelings of guilt than breast or prostate cancer patients, and as one doctor points out, when given a lung cancer diagnosis, patients must almost always answer the question, “Did you smoke?” (Else-Quest 949; Holland 362).

The language of prevention also encourages stigma. One study found that 70% of respondents attributed lung cancer patients with at least some blame for their condition, and 37% attributed blame to those with cervical cancer. Nearly everyone – 97 percent – believed that those who were obese were in part responsible for a cancer diagnosis (Marlow 1799). Thus, the rhetoric of responsibility that saturates the discourse on cancer prevention often degenerates into victim-blaming. Once we call low-fat diets or exercise regimes “virtuous,” then conditions related to other lifestyle choices demonstrate a lack of virtue. As one fed-up physician wrote, “Have we reached such a point in our ‘health

conscious' society that every individual who suffers an illness classified as "preventable" must bear the burden of responsibility for that illness? Why isn't it possible to just get sick without it also being your fault?" (Marantz 1186). The science of prevention is often accurate, and the rhetoric surrounding it can prove edifying – smoking can, of course cause lung cancer, and sunbathing does jeopardize your skin. Yet constant self-blame for one's own illness helps no one, and scorn for the sick undermines compassion. Moreover, calling sickness a sin equates a biological cure with holy redemption.

The belief that cancer is a product of individual choices, and that those individual choices represent some moral failing, allows the language of sin to slip into modern discourse on disease. Thus, when Clinton sought to collect more revenue from tobacco sales, the media christened his proposal a "sin tax" (Berke A14). The rhetoric rendered smoking more than a vice, but a sign of moral degeneracy. Similarly, a 1986 Hastings Center report explained that when guilty behaviors bring about cancer, then rejection of such behaviors is a "symbolic rejection of sin." Yet such expressions suggests that those who fall ill have succumbed to sin and now suffer the consequences. Philosopher and social commentator Renata Salecl explains that because a do-it-yourself ethic "now extends to our own bodies...the more we assume control of our bodies, the more terrifying any problem becomes." Thus, "health problems become the individual's ultimate sin" (55). A physician echoes her observation: "In many ways, to have a heart attack before the age of 60 is the modern equivalent of sin" (Spiro 297).

The language of sin thus fits into a pseudo-Christian narrative about the causes and consequences of cancer, one that posits the doctor as savior capable of washing away our transgressions. Illness suggests wrongdoing; poor health behaviors serve as sin, and

“the wages of sin is death” (Romans 6:23). As Dr. Marshall Becker explains, emphasis on personal health goals creates “a new religion, one in which we worship ourselves, attribute good health to our devoutness, and view illness as just punishment for those who have not yet seen the Way” (6). In various Christian traditions, Satan serves as the enemy, yet humans commit sin. So it is with cancer. We call cancer our foe, but, as Susan Sontag points out, even though “the illness is the culprit...it is also the cancer patient who is made culpable” (Sontag 57). Not only can we demonize the cancer, but we also can condemn the patient.

The Christian metaphor of sin becomes even more relevant in light of cancer’s genetic component. Media coverage of the BRCA mutation and its relationship to breast cancer has drawn attention to genetic predispositions to cancer development; in 2010, the journal *Nature Medicine* published an article about causes of cancer that began, “Blame your genes” (Abecasis). Thus, cancer seems built into our biological makeup, an internal fault passed down from parent to child over and over again. It thus operates like original sin from the fall of Eve and Adam, serving as both a mark of our humanity and a sign of our infallibility. Imperfection is written into not only our moral status, but also into our genes. Sinfulness is inherent to mankind; so is cancer.

Sir William Osler, known as the “Father of modern medicine,” once wrote that “disease and pain” are fundamental facts of “the real curse of Adam” (64). He makes explicit what our contemporary rhetoric suggests: cancer, among other diseases, is a sin caused both by less-than-virtuous behaviors as well as the (genetically) flawed state of man. There exist other discourses about cancer, of course, but the disease prevention movement has turned the sickness-as-sin narrative into a dominant one. Understanding

cancer as a sign of transgression places particular responsibilities upon the physician – after all, though the wages of sin may be death, “the gift of God is eternal life in Christ Jesus our Lord” (Romans 6:23). If disease is the sin, then the physician who banishes disease performs holy rites of redemption. Physician and essayist Richard Selzer writes of the link between surgeon and savior, disease and damnation: “You shall know surgery as a Mass served with Body and Blood, where disease is assailed as though it were sin” (Selzer 65). Medical treatment thus serves as a sacrament, purging us of our wrongdoing and reuniting us with the righteous. When the cancer is our enemy and the illness is a sign of our sin, then the place for a savior becomes clear – like a Christ figure washing the broken of their sins, the physician conquers the disease and restores the patient to virtuous health. It is no wonder, then, that Sir William Osler understood biomedical advancement as a way to rectify mankind’s fall from grace in the garden – in his words, modern medicine serves as the mechanism for “man’s redemption of man” (64).

FORSAKEN: CONSEQUENCES OF THE CHRISTIAN NARRATIVE

*My God, my God, why have you forsaken me?
Why are you so far from saving me,
So far from my cries of anguish?
My God, I cry out by day, but you do not answer,
by night, but I find no rest.*

Psalm 22:1-2

Therefore, my beloved, flee from idolatry.

1 Corinthians 10:14

In the Christian narrative, Jesus' sacrifice cleanses the sinner of her sin. Saved and sanctified, she spends eternity with God. When transposed onto the modern healthcare experience, a secularized Christology tells a similar story with a radically different ending. When doctors are Christ figures, diseases unholy enemies, and poor health a sign of inner fault, then the imperative at the end of life is clear: cure the patient and banish death. Salvation does not mean going to heaven; it means staying alive.

Because medicine itself can save, the thinking goes, we can spend an eternity not in God's kingdom, but in our own. The physician thus serves as a secularized savior, defending the ill from the evil of their disease. Rescued from death and washed clean of their sins, patients stand redeemed in the light of healthcare's glory. That's the story, anyway, but for all of biomedicine's state-of-the-art technology and innovative procedures and fancy drug trials, the institution of medicine has always and will always

fail in its quest for immortality. People die, and the secularized Christian narrative cannot contain that simple reality.

The savior we call the doctor will not always save. Yet despite its constant failure, the narrative persists. Christological constructions thus narrow the focus of healthcare to a single goal: the perpetuation of life. The war against cancer and the production of illness as a sin perpetuate the notion that life's end is the ultimate enemy. Our fear of cancer is our fear of death; our war on cancer is our war on death. When *The Economist* published an image of breast cancer as a grim reaper in a pink ribbon, it spoke to why the disease terrifies us – it can end our lives (see figure 1).

Figure 1: *A graphic in The Economist depicts breast cancer as a skeleton wrapped in a pink ribbon.*



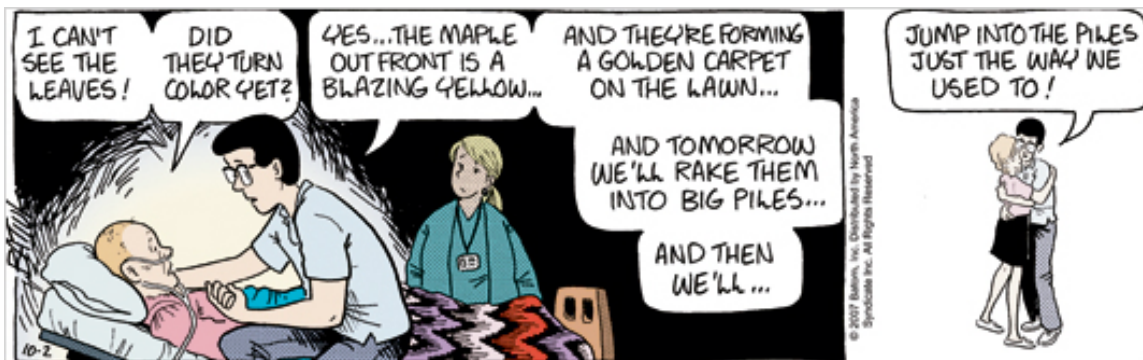
Medicine has thus become our reaction to the audacity of death. In fact, contemporary writers sometimes define medicine as action that postpones death. For example, in his 1999 book *The Greatest Benefit to Mankind*, historian Roy Porter writes of 18th century medicine, “Early modern times brought...brilliant breakthroughs in anatomy and physiology, but achievements proved more impressive on paper than in bedside practice. The war against death stalled” (245). Porter thus charts the history of medicine as the history of the war against death – at some points in time, it advances; at others, it “stalls.” His rhetoric constrains medicine to a singular purpose, and thus “the greatest benefit to mankind” is the advances we make against dying.

Secularized narratives of salvation thus play into a culture-wide death delusion: the assumption that we can and should control our own mortality. Death itself is the problem. It is the product of an accident, a medical mistake, some failing in scientific research. If we throw more money and time and ingenuity into the fight, then death can be overcome. Dr. Russell Harris, a member of a cancer therapy evaluation board at the NIH, expressed concern in a *New York Times* piece that physicians and patients alike fail to recognize the totality of our commitment to aggressive care. Obsessed with a no-holds-barred approach, “everyone is totally immersed in the idea that death is the enemy” (Kolata). By demonizing death, we render acceptance of it impossible. As Steve Jobs observed in a speech to Stanford’s 2005 graduating class, “No one wants to die. Even people who want to go to heaven don’t want to die to get there” (An Excerpt).

Our society’s fear of death manifests itself in various forms of cultural production – it even prompted a nation-wide debate about the content of newspaper comics. In the

widely syndicated cartoon strip *Funky Winkerbean*, one of the primary characters, wife and mother Lisa Moore, dealt with breast cancer for nearly eight years of the strip's existence. In October 2007, she passed away in peace after she halted her chemotherapy regimen and transferred to hospice (Gustines). The comic strip shows her dying in the embrace of her husband, a helpless doctor off to the side (see figure 2). Lisa Moore chose a path that terrifies countless Americans; she refused treatment, opted for hospice care, and prepared for her own passing. At the moment of her departure, her doctor was a companion rather than a savior. *Funky Winkerbean* thus challenged the narrative that demands for secular salvation, proposing an alternative way to approach the end of life.

Figure 2: *Lisa Moore, beloved character of Funky Winkerbean, passes away.*



Moore's decline and death stirred deep controversy about the story's appropriateness – death, many readers argued, did not belong in the funny pages. The controversy resulted in an NPR story, ABC News coverage, and a *New York Times* article (Parker-Pope). The cartoonist Tom Batiuk, later a 2008 finalist for the Pulitzer Prize, weathered a firestorm of complaints. One reader wrote, “You are a man who seems to be without any idea of the pain [you] are inflicting... You do not have the right to put this

horror in a family newspaper” (Coverson). Apparently much of the American public could not handle a story about death, no matter how compassionately Batiuk portrayed it. One editorial cartoonist covering the controversy depicted the grim reaper reading the newspaper and laughing (see figure 3). The political cartoon had taken a sensitively wrought story about a wife who dies in the embrace of her husband and turned into the dark sort of death associated with the grim reaper. The image thus demonstrates that no matter peaceful a death may be, it is difficult for the public consciousness to disassociate it from images of the macabre. When readers of the funny pages decide that topics like cancer, hospice, and the end of life constitute “horror,” then we know that our societal grasp on death is tenuous at best.

Figure 3: *The grim reaper laughs at a comic strip character’s death.*



It wasn't always this way. Various cultures throughout history, though perhaps never fond of death, developed rituals around the dying process that incorporated death into not only the life of an individual, but also the life of a community. In the early 15th century, the medieval version of a bestseller, the *Ars Moriendi*, offered a set of texts that, like many others circulated during the time, described the "art of dying." It was a handbook of sorts, a tract for those approaching the end. The *Ars Moriendi* began with consolation, a reassurance that death in of itself was no evil. It then cautioned against despair at the end or impatience with suffering, explaining that there was good to be had in not only death itself, but also the dying process (Thornton; Leget 313). Dying, it explained, meant an elegant goodbye to family and friends, one that included prayer and exchanges of forgiveness and blessing. There was no place for aggressive interventions, for last-minute measures, for attacks against an enemy called disease. Instead, historian Philippe Aries calls it a "tame death," a death that tied up loose ends and prepared the dying to meet their maker (Verhey 11). Indeed, preachers in the 13th century told churchgoers to "remember death" and ready themselves for it (Hauerwas 98). How one died, they believed, affected how one would live on after death. To die without confessing your sins would mean dying into an eternal hell, and to those in the medieval period, dying suddenly, unawares and without atonement, constituted the worst type of death. Our contemporary fear of death has inverted the preference; dying without knowing seems ideal, and so we derive comfort when others die in their sleep.

The course of cancer thus runs counter to how we would like to die. It progresses in stages, with our full awareness, thus giving us plenty of time to prepare for the end –

or, more likely, fight against its possibility. Fear of cancer, then, is not only fear of death – it is fear of what we so often see as the worst kind of death: a slow one. Without a communal sense of what preparation for death ought to look like, the “tame death” Aries describes has transformed into a death-without-rules, a death-amidst-battle, a death defined by failing technology and a protracted loss of consciousness. Theologian Allen Verhey explains that when machines now “pump blood and move breath,” death itself becomes a technical event, one that requires expert diagnosis (16). This is not dying because it is time to die; this is dying because the doctor cannot do anything to get us to keep on living. According to Aries, we have lost the “tame death” for something more chaotic and less communal – the “wild death,” messy and medicalized.

Death and the Individual

When ignorance of death becomes not only the ordinary but also the ideal, we turn to stories of medical salvation to mask the prospect of the end of life. It is a faith constantly challenged, for every death suggests that seemingly omnipotent medicine cannot accomplish all that it may promise. The real problem with the secularization of Christian storylines, however, is not simply that they do not describe reality. Ultimately, our cultural narratives shape our individual actions. We ought to take issue with the characterization of the doctor, the disease, and death itself because the stories about the function of healthcare that pervade our cultural consciousness actually perpetuate grief and pain at the end of life.

Medicine committed to a project of salvation all too often overlooks and ostracizes the patient who cannot be “saved.” The narratives we tend to tell about cancer and death leave some people out, for there is no room in stories of medical rescue and biological redemption for the patient who is about to die. Sharon Begley, senior health and science correspondent at *Reuters*, explained in a *Newsweek* article that media coverage of cancer follows particular journalistic formula. She explains,

There is a blueprint for writing about cancer, one that calls for an uplifting account of, say, a woman whose breast tumor was detected early by one of the mammograms she faithfully had and who remains alive and cancer-free decades later, or the story of a man whose cancer was eradicated by one of the new rock-star therapies that precisely target a molecule that spurs the growth of malignant cells. It invokes Lance Armstrong, who was diagnosed with testicular cancer in 1996 and, after surgery and chemotherapy beat it back, went on to seven straight victories in the Tour de France. It describes how scientists wrestled childhood leukemia into near submission, turning it from a disease that killed 75 percent of the children it struck in the 1970s to one that 73 percent survive today.

These are tales of victims who become victors, challenges that become triumphs, and technology that wins the war. Even if the story ends in death, the patient becomes the tragic hero. Obituaries often begin, “after a long battle with cancer...,” and thus turn the patient into a warrior who shed blood and lost life on the battlefield in the most noble of deaths. A week after Senator Ted Kennedy received a diagnosis of brain cancer, he competed in a sailing race and made international news for what his wife, in keeping with the rhetoric of militarism, later called “tackling cancer with grit” (AP). Awed by his courage, media sources around the world cheered, “Fight, Ted, Fight!” (Hoffman). When he passed away, obituaries celebrated him for his “long battle” and “determination to persevere” (Bendavid; Thomas). Kennedy’s death demonstrates the testosterone-charged

language often used to describe the experiences of those claimed by cancer. Thus, the salvation narrative does allow us to praise the patients who die, but we praise them for the same qualities we see in “survivors.” We applaud them for their courageous resistance to the enemy, for fighting the good fight, for, as poet Dylan Thomas would say, “rag[ing], rag[ing] against the dying of the light.”

Yet if these are the stories we hear, what happens when one’s experience of suffering doesn’t follow the script? Narratives of heroism create counter-narratives of cowardice, and hearing about victory makes it difficult to accept “giving up.” Militaristic language can alienate the patient who wants to talk about options for the end. If patients are supposed to keep fighting, are they failures if they stop? What if they don’t want to raise the battle cry once more? Many feel the pressure of the metaphor; refusing the next attack on the enemy means retreat in the war (Hoffman). The rhetoric that surrounds the cancer battle, then, can create a culture of denial. Even when provided with their prognosis, one-fourth to one-third of patients refuse to believe that treatment cannot cure them (Smith, Mitera). Thus, an obsession with technology’s power to stave off death ultimately denies the reality of suffering and neglects the experiences of the sufferer.

A medical culture deaf to a discussion about death generates an overreliance on the sacra-medical function of the physician. If doctors are supposed to save, then the last stages of life cry out for a miracle. It is no wonder, then, that treatment for the last year of life consumes 25% of Medicare expenses; the nearer a patient inches towards death, the more justified biomedicine is in heroic (and costly) attempts at salvation. “How do so many people end up in the hospital?” asked a 60 minutes correspondent in a 2009

program. A researcher at the Dartmouth Institute for Health Policy replied, “It’s the path of least resistance” (Court).

The incentives are clear: aggressive care not only brings in hospital profits, but it also allows all parties to avoid difficult decisions about the end of life. American healthcare is thus calibrated to launch its patients into the most aggressive of treatment pathways. After entering the system, the patient receives diagnosis after diagnosis and begins treatment after treatment. In her book *The Best Care Possible*, Dr. Ira Byock, worries, “It’s a dysfunctional system that feels like a conveyor belt. We have a disease-treatment system rather than a healthcare system.” The doctor gets to feel like a savior, the patient gets to feel like the saved, and faith in the cathedral called the hospital pushes the prospect of death to the corners of consciousness.

Yet the physician cannot save everyone, and faith in aggressive intervention has transformed the face of death in America. Until the middle of the 20th century, people died at home (Aires 559). With the advent of new technology that generated hope in medicine’s power, two-thirds of death occurred in hospitals by the 1960s. Now, 75 percent of Americans die in a hospital or nursing home, and a staggering 18 to 20 percent spend their last days in an Intensive Care Unit (Court). Death thus comes after a frantic assault of last-ditch desperate measures rather than a peaceful acceptance of the end. As Byock explains, “This has become almost the medical last rites for people as they die.” Thus, the practice of aggressive intervention becomes a religious ritual, a ceremony in which the physician attempts to play out her function as the savior. Yet although patients themselves opt for aggressive treatment, no one wants to die in the hospital. A vast

majority of Americans state that they would prefer to die at home, but because it is much easier to say *yes* to the next treatment than *no*, most attempt to fight until the end.

The battle comes at a high price. Attempts to stave off death often sacrifice quality of life, and research demonstrates that aggressive treatment often renders patients less satisfied with their healthcare than palliative care alternatives (Am 54). Moreover, though families often urge doctors to do everything they can, those whose loved ones receive more intensive treatment are more likely to feel that their patient has not receive adequate care (54). Often fueled by denial, aggressive measures also make it difficult for caregivers to cope with loss. Studies find that the family members of patients who died after an onslaught of interventions often struggle with crippling grief when compared to those whose loved ones chose palliative, non-curative treatment (Wright). Faith in biomedicine thus complicates the bereavement process; when the narrative of secular salvation fails the devout, disillusioned family members must learn to abandon a constant characterization of death as the enemy.

As if painful death and painful grief weren't enough, those who adhere to belief in medicine's godlike powers must contend with a final blow to the sacra-medical narrative: high-cost interventions, as a whole, often fail to extend life. Various studies have found that spending pumped into the end of life rarely lengthens it (Am, Skinner). In fact, in an ultimate show of irony, a 2010 landmark study found that patients who choose non-curative, palliative care, live on average 2.5 months *longer* than patients who opt for standard treatment. They also report better mood, higher quality of life, and less intense symptoms (Temel 733). Biomedical doctrine, then, does not even accomplish what it sets

out to do; caught up in an aggressive pursuit of a miracle, many patients miss out on a less dramatic but more meaningful alternative: a good death.

If research about the downsides of aggressive interventions proves so conclusive, why do so many patients choose them? Part of the problem lies in a lack of communication. According to a 2012 survey in California, 60% of people say that making sure their family is not burdened by difficult end-of-life decisions is “extremely important.” Yet 56% of individuals have not actually spoken with their families about their end-of-life desires (CHCF). Fear of death creates a contradiction: we don’t want to talk about the end, even if we have opinions about what it should look like.

Yet patients are not the only players who sense a taboo on conversations about the end of life. The ill may sometimes have a hard time discussing their death, but so too do the doctors who feel that they must save them. As one physician explained, “This is the hardest conversation for doctors to have. A lot of doctors wait for someone to bring it up” (Brody). Talking about the end of life requires doctors to forsake their cultural identity as the infallible savior and admit that modern medicine cannot play God. For some physicians, honesty feels like defeat, and any reduction in treatment stings like a personal failure. When asked why he and his patient pursued a therapy he knew to be futile, one oncologist explained, “I don’t want Judy to think I’m abandoning her” (Brody). Unable to cope with the reality of death, the doctor offers another drug trial, a second surgery. Yet tests and treatments drawn from the toolkit every doctor gets during training don’t prepare physicians for the time when the toolkit fails. In fact, most doctors do not feel equipped to have conversations about difficult decisions; 73% of cancer physicians said

they never received adequate prognosis communication training, if they received it at all (Daugherty 5988).

Consequently, many doctors choose not to engage in any palliative care conversations whatsoever. Though two-thirds of physicians tell their terminal cancer patients at the first visit that their disease is incurable, only one-third ever give their patient the actual prognosis at any point during their illness (Kiely 380). Silence proves easier than speech, and the extent of the taboo borders on the absurd: two months before death, about half of all lung cancer patients have not heard their doctors use the word “hospice” (Huskamp 954).

A lack of discussion precludes informed decisions about the end, and on average, patients who never speak to their doctors about the end of life choose more aggressive care and experience a lesser quality of life than those who have had those conversations. A lack of clear medical consultation leaves patients confused about their options. A recent study found that 69% of patients with stage 4 lung cancer and 81% of patients with stage 4 colon cancer did not understand that “chemotherapy was not at all likely to cure their cancer” (Weeks 1616). With an unrealistic understanding of their chances – brought about, presumably, because physicians never properly communicated the facts – patients plunge into painful and costly chemotherapy and postpone a transfer to hospice, sometimes sacrificing their chances for a peaceful end. To make matters worse, bereaved caregivers who did not remember any end-of-life discussions with physicians experienced more regret and a higher risk of depression than their more informed counterparts (Wright).

Yet conversations are no magic bullet. Even doctors who engage their patients in discussion often struggle to communicate the reality of the diagnosis. Anyone familiar with the statistics will know that for many cancers at various stages, surgeries often fail. Yet the statistics matter very little when anxious doctors attempt to reassure anxious patients and families – if the doctor’s imperative is to save, then it is all too easy to hope beyond hope that perhaps this procedure and this patient will be the exception. Thus, when confronted with the possibility of death, many doctors cushion bad news while infusing advice with hope. One study showed that many physicians spend little time discussing the prognosis with patients, instead transitioning almost immediately into a gung-ho discussion of treatment options and scheduling (The 1376). By diverting everyone’s attention, the conversation encourages false optimism.

Denial and distraction dominate experiences at the end of life. If cultural narratives portray the doctor as a savior, then for all involved, every death is a disappointment. All too often, physicians and patients would much rather hope for a miracle than plan for the probable, and so the biomedical machine whirs on. Healthcare professionals occasionally toss around an old joke about the absurdity of their culture:

“Why do they put nails in coffins?”

“To keep the oncologists out.”

(Chatfield)

Death and the State

The effects of cultural narratives reach beyond the individual; they shape entire institutions. America's salvation project has seeped into the very structure of healthcare. Even though the history of anti-cancer rhetoric has often linked it to a nationalistic crusade against death, an overabundance of trust in biomedicine ultimately places crippling financial burdens on the state. Hope comes at a high cost. It takes up to \$10,000 a day to maintain a patient in an intensive care unit; many stay for months (Court). A 2012 *Newsweek* article begins, "\$33,382 for one hospital stay. \$43,711 for the next. And a final \$14,022 for the last three days of life." The article concludes, "This is the price tag of dying in America" (Am). From the 1970s to the 1990s, the cost of adding one year to the life of an individual over 65 years old more than tripled (Am). Now, one quarter of Medicare outlays go towards the end of life (Hogan 188). In 2009, Medicare paid \$55 billion for healthcare bills during the last two months of life. As CBS news points out, that figure is greater than the budget for the Department of Homeland Security or the Department of Education, even though studies estimate that 20 to 30 percent of those costs may have had no impact on postponing death (Court). Money talks, and when billions of government dollars go to aggressive interventions, we know that staving off death for those at the end of life has become one of the nation's priorities.

The government's focused financial commitment skews funding in other realms. Not surprisingly, an overreliance on aggressive care strips resources from alternative approaches to death. Despite well-documented benefits of palliative care, government grant money goes to more dramatic research initiatives. In fact, the vast majority of

funding in the war on cancer focuses on patients with advanced illnesses and less than a 20% chance of survival (Lobos). Money funnels into research with heroic goals – to late-stage rescue attempts with its impressive technology and daring science.

Palliative care, on the other hand, not only lacks funding, but also people. Research points to an acute shortage of hospice and palliative care physicians; one study estimates that the current system needs up to 18,000 more doctors to fill the deficit, a number nearly half of the current total of hospice and palliative care physicians. End-of-life care, it seems, is just not what many physicians went into medicine to do. Moreover, even if more students pursued palliative care, the capacity of fellowship programs currently in existence is not even large enough to meet the demand (Lupu 899). To make matters worse, most medical schools do not include a hospice rotation – apparently, those who structure curricula do not consider dealing with death a core component of a doctor's education (Maison).

The state also creates a financial disincentive for doctors to spend time talking about the end of life. Though effective end-of-life counseling requires time and training, physicians cannot bill Medicare for the service (Lowes). Yet not only does the payment structure perpetuate discomfort with death, but discomfort with death reinforces the payment structure. In 2009, the healthcare reform bill proposed by the Obama administration included financial reimbursement for time spent in end-of-life conversations. The proposal now remains infamous, burned into national memory as a provision on “death panels.” Sarah Palin popularized the phrase in a Facebook post and ignited nationwide panic; soon after, protestors marched in DC wearing masks that

mirrored Edvard Munch's *The Scream* and shirts featuring a grim reaper version of Barack Obama (Lepore).

The words “death panel” terrified much of the American public. It recalled Nazi-style domination, suggested government-enforced euthanasia, and ultimately inverted the traditional salvation narrative in medicine. Instead of Christ-figures who save, healthcare authorities became God-figures who condemn. In the words of Iowa senator Chuck Grassley, “You have every right to fear.” The government, he concluded, “should not...decide when to pull the plug on grandma” (Montopoli).

Though other politicians rushed to debunk the “death panels” myth – to the “pulling the plug on grandma” comment, Obama wryly replied, “I am not in favor of that” – a Pew Research Center poll found that a week after the phrase appeared, a stunning 86% of Americans had heard of the “death panels” provision, and of those who had heard of it, 30% believed it to be true and 20% were unsure (Lepore; Nyhan). The mischaracterization hijacked what could have turned into a national conversation on how to approach the end of life. The reimbursement provision had become a political bomb, and Democrats stripped it from the legislation (Parsons). The language of death panels continues to haunt those hoping for change; even when politicians reintroduced a similar provision to healthcare legislation in 2011, political pressures forced them to remove it once more. The rhetoric of death, then, has stopped reform in its tracks.

The death panel debacle hints at a larger crisis in American medicine. We feel comfortable paying for expensive interventions, but not for the conversations that ask whether we ought to pursue intervention in the first place. Medicine, then – at least the

type of medicine we will let our country pay for – is narrowly defined as action that extends life.

The narrative that encourages a denial of death is not monolithic; there are plenty of patients who opt for palliative treatment and choose the route of acceptance rather than aggression. Moreover, there is nothing inherently wrong with medical interventions – medicine can sometimes work miracles, and treatment often gives the sick years of high-quality life they otherwise would not have. I neither blame nor belittle those who choose to fight their illness with all they have. Yet it must be a fully informed choice, made after honest conversations with their doctors and their families about their chances for living and their desires for dying. Fear of death and faith in medicine, however, too often preclude these conversations, and when the doctor can't be our savior, devotion to the doctrine of biomedicine cannot prepare us for the end.

EPILOGUE : RETHINKING SICKNESS, RECLAIMING SALVATION

Where, O death, is your victory?

Where, O death, is your sting?

1 Corinthians, 15:55

Americans don't know how to die. For the most part, however, they know how they want to die – outside the hospital, in peace and without pain. Why, then, does the vision become a reality for so few? When actually confronted with the possibility of death, countless patients, physicians, and families strive to extend life at all costs. Last-ditch interventions, a dearth of palliative care consultations, costly Medicare bills from weeks spent in the ICU – all are symptoms of a larger societal death-disorder, a pervasive fear of dying that paints the doctor as the savior and the disease as the enemy.

Though the fear of death haunts all forms of life-threatening illness, cancer, the country's most dreaded disease, crystallizes it. In response to the possibility of cancer-related death, Americans often cling to a secularized version of the Christological narrative. The doctor is the savior, cancer is the leviathan, and illness is the sign of sin. The progression of the Christian story of salvation thus fashions a *telos* for modern medicine: the doctor washes away the sin, chases away the enemy, and ultimately rescues the patient from the brink of their demise. We see pieces of the narrative in white coat ceremonies and primetime medical dramas, in newspaper headlines that sing of saviors

and lobbying efforts that cry out for war. We see it whenever we deem cancer demonic or hail survivors as victorious. We see it in drawings of grim reapers or hellish crabs, in rhetoric that calls smoking a sin and early-morning runs a virtue. Most importantly, however, we see it in the way Americans approach the end of life.

There is, quite frankly, no room in a medicalized salvation narrative for the intractability of death. We thus narrate death as some sort of technological failure, a problem we could fix if we only worked harder at it. Patients, families, and doctors thus rally around a common battle cry: everything that *can* be done *ought* to be done.

When faced with broken bodies, we all too often place our faith in an antiseptic authority, a glass-walled cancer center, a gleaming surgical world. We worship in the cathedral we call the hospital, desperately pinning our trust to technology that promises to stave off death. Life indefinitely extended is the ultimate goal. The end is the ultimate enemy. Ultimately, after applying a Christological narrative of salvation to the secular crusade against death, we end up with what theologian Stanley Hauerwas calls the paradoxical imperative of modern-day medicine: to get out of life alive (Hauerwas, War, 19).

The Christological metaphors that abound in disease discourse do not simply describe realities – they create them. When doctors who view themselves as biomedical saviors confront the messy reality of unalterable disease, they experience profound feelings of failure. When patients trust in the saving grace of the medical establishment and fear the death a demonic disease might force upon them, they avoid conversations about the end.

Secularized narratives of salvation thus hold healthcare back, limiting it to the realms in which modern medicine can perform miracles. Consequently, the medical establishment as a whole cannot meet patients in their deepest need at the end of life, for last-ditch desperate measures do not allow us to contend with the reality of death. Medicine's ability to heal is one of society's greatest triumphs. Yet medicine's *desperation* to heal is one of its greatest challenges. Healthcare that does not prepare for the reality of death – that does not even, in many cases, acknowledge it – is healthcare that neglects its patients in the most critical of moments.

Death is daunting. Fear is natural. Yet some forms of fear prove paralyzing. When doctors are afraid to speak honestly with their patients, when patients are afraid to speak honestly with their family members – when decisions are left unmade and wishes left unsaid, then the fear of death cripples any chance of a peaceful passing. In order to change the way we understand the end of life, we must first recognize and respond to the narratives that frame our interpretations of modern medicine. Doctors and patients who create counter-narratives about how we ought to die will challenge the culture of biomedicine that focuses on curing rather than caring.

We should treasure modern medicine, but we cannot place our faith in it. No longer can we afford to rage away in a quixotic quest against the end. It is time to lay down our arms. It is time to talk about what frightens us. It is time to rethink our definitions of savior and Satan, salvation and sin. Only then can we honor life rather than idolize it, and only then can healthcare offer one of the most beautiful gifts a patient can receive: a good death.

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Figure 6:

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